



AAMC

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Policy Priorities to Improve the Nation's Health

from America's Medical Schools and Teaching Hospitals



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Darrell G. Kirch, M.D.
President and Chief Executive Officer

Dear President-elect Obama:

Our nation faces extraordinary challenges and tough choices in the coming months. The Association of American Medical Colleges (AAMC) stands ready to work with the Obama administration and Congress to help fashion and implement solutions that will strengthen the health of our nation and its commitment to serving the public good. The enclosed binder outlines the policy priorities we believe will help achieve these goals.

The mission of the AAMC is to serve and lead our members—the nation’s medical schools and teaching hospitals—to improve the health of all. A not-for-profit 501(c) (3) association, the AAMC represents all 130 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 75,000 medical students, and 106,000 resident physicians.

Our members play a significant role in the U.S. health care system by educating and training future physicians, providing quality health care for all patients, and promoting discovery and innovation through biomedical, behavioral, and health services research.

Each year, 17,000 individuals are awarded doctorates of medicine (M.D.) from AAMC-member medical schools. These new physicians have been educated and trained alongside physician-scientists and other health professionals at the nation’s teaching hospitals (and their outpatient departments) where millions of Americans turn for complex state-of-the-art treatment and life-saving care. Although AAMC-member teaching hospitals account for only 6 percent of all acute care hospitals and 22 percent of all hospital discharges, they provide 41 percent of all charity care, and 28 percent of Medicaid inpatient care.

In addition to providing education and clinical care, the long-standing partnership among the nation’s medical schools, teaching hospitals, and the National Institutes of Health (NIH) greatly advances America’s scientific knowledge. More than 50 percent of the nation’s 7,000 new biomedical scientists earn their Ph.D.’s from AAMC medical schools each year. AAMC member-institutions are also major centers of biomedical and health services research where the NIH invests nearly half of its \$29 billion budget to support the discovery of groundbreaking cures and treatments.

The AAMC and its members look forward to working with the Obama administration to promote policies that will benefit all Americans by strengthening our nation’s system of medical education; ensuring that safe, quality care is provided to all who need it; and enhancing our country’s commitment to scientific discovery and innovation that promotes health and improves the treatment and prevention of disease and disability. The AAMC also has a set of principles that our community believes should guide any future health care reform discussions.

The information in this binder is also available on the AAMC’s Web site at www.aamc.org/advocacy/obamatransition.pdf. We hope you find the following materials helpful in explaining the issues of importance to the nation’s medical schools and teaching hospitals, and the integral role these institutions play in improving and protecting the health of all Americans.

Sincerely,



Darrell G. Kirch, M.D.
President and CEO



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AAMC Principles for Health Care Reform

The U.S. health care system faces a crisis of access, cost, and quality that must be addressed now. The Association of American Medical Colleges (AAMC) and its members believe that ensuring access to safe, high-quality, appropriate, and affordable patient-centered health care is, and should continue to be, the focal point of all health care reform discussions. Broadly defined, access is the timely, efficient, and effective provision of the most appropriate treatment for all in the most appropriate setting.

The U.S. health care system is recognized for discovering and providing life-saving treatments for many of the most difficult diseases and conditions and for educating a highly skilled health care workforce. Yet, at the same time, many believe that in its current form it is on an unsustainable course. The current system is costlier than other nations' health care delivery systems, does not provide insurance coverage for all, does not adequately emphasize preventive and primary care services, and is characterized by wide variation in utilization and the quality of care delivered. Because of these and other factors, our health outcomes lag behind those of many other nations.

In addition, many observers have concluded that our current health care system is poorly positioned to respond to the growing demographic and lifestyle issues that promise to exacerbate health care costs and create barriers to access in the future. These core issues mandate that the United States reexamine its health care system.

AAMC members, including 130 medical schools, nearly 400 of the nation's major teaching hospitals and health systems, 109,000 faculty members, and more than 180,000 medical students and resident physicians, represent a significant presence in the U.S. health care system. AAMC members educate and train the nation's future physicians and provide sites for the clinical education of other health care professionals. These institutions and individuals also care for large numbers of the uninsured and those in need of specialized services unavailable elsewhere in their communities. Their presence in the U.S. health care system is disproportionate; AAMC nonfederal member teaching hospitals and their clinical staff account for 6 percent of all acute care hospitals but provide 41 percent of all charity care and 28 percent of Medicaid inpatient care. The National Institutes of Health (NIH) also invests nearly half of its \$29 billion budget in medical schools and teaching hospitals, recognizing their unique ability to advance scientific knowledge alongside education and clinical care.

In light of its significant role in the delivery of health care, the education of future practitioners, and the creation of new knowledge, the AAMC believes that the academic medical community must play an integral role in identifying and implementing health care reform. Such reform must include improving delivery systems as well as financing health care while preserving the greatest strengths of the current health care system.

The AAMC has developed the following principles to help guide health care reform discussions. These principles will be used by the association to evaluate reform proposals, but they are only a first step. The AAMC will subsequently prepare a series of discussion and position papers that it hopes will provide a launching point to improve delivery of care, scientific discovery, and the education and training of the nation's health care professionals in the association's member institutions and the nation.

The AAMC and its members are committed to the following principles and believe that academic medicine must play a pivotal role in improving health and health care and in achieving positive changes in the health care system. We believe that, with a concerted national effort from both the private and public sectors, the goal of affordable, quality health care for all is achievable and sustainable within the next decade.

1. **Health care coverage that is affordable, transportable, and continuous, and that combines the best of public and private systems, should be available to all.**

All individuals must have health care coverage to benefit from an improved delivery system. "Coverage" refers to insurance or equivalent mechanisms that help to assure the delivery of necessary preventive, acute, and chronic care required by an individual and—ultimately—the overall population. Lack of health insurance coverage is the single most common barrier to access in the current health care system.

Individuals who do not have adequate coverage for significant periods of time are less likely to receive preventive care and more likely to have serious health problems diagnosed at a later stage. Without adequate health care coverage, an improved delivery system will still be plagued by the unnecessary loss of healthy and productive years of life for the population and inefficient use of resources for society. Even the vast majority of Americans who have private or publicly funded health insurance are vulnerable to lapses in coverage due to changes in employment or other factors that affect insurance status. Viable mechanisms to maintain

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coverage must be available for individuals who change jobs, or if their eligibility for insurance changes for other reasons, to ensure continuous coverage.

Reform initiatives should analyze and preserve the best elements of both public and private systems. As we deliberate how best to achieve coverage for all, innovation will be required. State and local delivery systems have long been an incubator for change, and they should have the freedom to continue to innovate and test new approaches. The correct balance between federal and state control and the role of the private sector will need to be determined as part of this process.

2. The health care delivery system must be restructured to facilitate health promotion and disease prevention while providing high-quality, cost-effective diagnosis and treatment of illness as well as palliative care.

The current delivery system is disjointed and lacks the necessary infrastructure and processes to achieve optimal results. An improved delivery system should help enable professionals to provide coordinated patient-centered care—including medical homes—by improving communication among providers and patients.

Policies aimed at improving coordination and integration of care must be strengthened to enable providers to function more efficiently and effectively. An electronic health record, that ultimately is interoperable, is a critical component of the changes necessary to correct these flaws and must be available for everyone as soon as possible to facilitate effective and efficient health care. The health care delivery system should also be better coordinated with the nation's public health systems to optimize opportunities for improving both individual and community health.

All individuals should have options available regarding health plans and providers, and meaningful support in decision making also should be available to diverse consumers. This support should empower providers and patients to help reduce the nation's health disparities and encourage value in spending while not discouraging patients from obtaining necessary, valuable services because of cost-sharing disincentives. Care should be centered on patients' needs and preferences, with shared responsibility among patients, providers, and payers. The health care system should also be easily navigable to allow patients to actively participate in their own care.

3. Health care financing mechanisms should be sustainable, equitable, explicit, accountable, and promote efficiency and quality.

The health care delivery system, and health care itself, are influenced by incentives embedded in the health care financing system. The health care financing system and payment policies should be designed to promote the delivery of efficient, high-quality patient and family-centered care that is affordable to the individual, the family, and the nation. To the extent possible, payment policy decisions should be premised on evidenced-based guidelines.

The United States currently has a pluralistic system of financing health care that includes employer tax incentives and employer-sponsored insurance, public insurance for the poor and the elderly, cost shifting between insured and uninsured sources, and individual payment for insurance and health care services. The current system makes efficient delivery of care difficult because of factors such as the number and complexity of insurers, providers, and funding mechanisms. This complicated financing system significantly increases administrative expenses and other costs of health care and, therefore, should be simplified.

Ultimately, no nation can provide all possible care to everyone who wishes it. If the nation believes that a finite set of resources (whether defined as absolute dollars or as a percentage of the nation's gross domestic product) should be devoted to health care, the pursuit of unlimited and potentially unnecessary services for some individuals may create ever-widening inequities and cost escalation and restrictions on basic services for others. A core level of services could be available to all, while a broader set of services could be available to those who choose to allocate additional resources for these additional services.

Some key drivers of escalating health care costs are an expanding and aging population (including a doubling of the population aged 65 and older), overuse of some diagnostic and interventional treatments, and administrative inefficiencies. Costs also are increased by redundancies, inconsistencies, and inappropriate variations in care. These multiple drivers are not amenable to any single strategy for cost reduction, and a variety of approaches will likely be necessary. If done appropriately, cost-reduction strategies can lower cost growth without reducing essential commitments to quality, access, and value.

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- Existing programs that serve defined populations should be maintained until superior alternatives can fully replace them.

The AAMC recognizes and supports the need for change in the overall health care financing and delivery structure. We also recognize that implementing new programs and structures will take time. Consequently, we believe that current programs should be supported until we are sure the replacements, as determined by a variety of criteria, are better and more rational than the systems they would be replacing.

This is particularly true for the patchwork of current mechanisms that finance care for the poor. “New” plans should not be financed prematurely by reducing or eliminating current mechanisms that include public payment systems and special payments to safety net providers, such as community health centers, state and county hospitals, and academic health centers. We must avoid the lure of terminating existing programs before new ones are proven and established. Not doing so would jeopardize the care provided to millions of vulnerable patients.

- The supply of health care practitioners must be adequate and reflect the population and its health care needs.

Even if efficiency is improved and unnecessary care is eliminated, access to appropriate health care services will not be possible unless the nation expands its health professional workforce, an effort that will require a substantial investment. The predicted future shortage of physicians, as well as nursing, pharmacy, dental, and other medical professionals, has been well documented. Without a workforce expansion, access problems for all—but especially for those in underserved communities—will be exacerbated.

Serious efforts must be made to expand the number of health professionals educated to care for a population that continues to grow and whose aging will place unprecedented demands on the health care system. The costs of educating and training physicians, in particular, are exceptionally high compared to the costs of other professions because of the extensive duration of physician education and the need for education in a clinical environment.

And just as the health care delivery and financing systems must identify ways to improve efficiency and quality, academic medicine must also assess the educational process to determine whether it can become more efficient, while maintaining and improving the goals of achieving a

high-quality physician workforce that both reflects the population and meets its health care needs. Changes in the delivery system will affect how clinical education is conducted, and the education process must reflect this.

The costs of physician education and training have traditionally been borne by a complex variety of sources, particularly the trainees, the medical schools and teaching hospitals that train them, and the government. As the system is transformed, these costs will continue and may even rise as adjustments are made to the content of the education, sites of education, number of students, and the expanding scope of knowledge. Given the impending physician shortages, it will be important to identify stable funding sources that will expand and build upon existing mechanisms.

We must also address the geographic disparity of providers. Health care professionals are virtually absent in some communities; nearly 30 million people live in federally designated underserved communities. While improved access may be facilitated by coverage for all, coverage alone will not ensure access. The nation must work to develop policies that create appropriate, effective incentives for health providers—whether nurses or generalist or specialist physicians—to locate in communities of need supported by services such as telemedicine, regional health networks, and other innovations.

Finally, the health care workforce should reflect the underlying diversity of the nation and support continued improvement in health status across diverse communities. This will require attention not only to geographic disparities but also to ethnic disparities, the needed mix and location of primary and specialty providers, and to the relationships between providers and the patients and communities they serve.

- Any reconfiguration of the health care system should recognize and provide stable support for the costs inherent in health research, technology development, and the provision of necessary specialized services to the broader society.

Research, and the development of medical and health systems knowledge, is the keystone to a vibrant “learning” health care system. These efforts have inherent costs largely borne by the government, academic medical community, and device and pharmaceutical companies. This work will become increasingly important as we strive to enhance the evidence base for care processes and evaluate their relative effectiveness.



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Medical education is enhanced when it occurs in a setting where research is conducted, so that future physicians and other professionals learn not only current knowledge, but also are exposed to the intellectual aspects of discovery and areas for exploration inside the professional context of continuous learning and inquiry. Research, education, and patient care should not be isolated from each other. This collaboration can only be accomplished with recognition and understanding of the full costs of these interrelated activities and if adequate, stable support is available. Any changes to the delivery system should strive to allow this synergy among the closely interrelated missions of academic medicine—education, patient care, and research—to continue.

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Physician Workforce Issues

Issue

The United States is facing a serious shortage of physicians and other health professionals, largely due to the growth and aging of the population and the impending retirements of older physicians. The impact of this shortage will disproportionately affect vulnerable and underserved populations in the United States. Currently, more than 60 million people live in rural or inner-city locations that have been designated as health professional shortage areas. Moreover, the existing physician workforce does not reflect the racial and ethnic demographics of the U.S. population, making the provision of culturally competent care more challenging in an increasingly diverse nation.

Any effort to improve access to health care must address coverage and delivery improvements as well as the shortage of physicians.

Background

Between 1980 and 2005, the nation's population grew by 70 million people—a 31 percent increase. By 2030, as baby boomers age, the number of Americans over age 65 will double from 35 million to 71 million. These changes will significantly increase the demand for physicians' services because patients 65 and older typically average six to seven physician visits per year, compared with two to four visits annually for those under age 65. While medical advances and enhanced prevention will enable Americans to live longer, healthier lives, these individuals will also require additional health services as they age.

The Association of American Medical Colleges (AAMC) recently updated its analysis of future supply and demand for physicians under a variety of scenarios. While physician supply is projected to increase slightly between now and 2025, demand is projected to rise at a far faster rate, yielding a shortage of 124,000 or more physicians by the same year. While most specialties will face shortages, primary care specialties already are experiencing shortages likely to worsen in the coming decade. These shortages are expected to have a disproportionately negative effect on those populations that are already underserved; the Health Resources and Services Administration (HRSA) estimates that an additional 30,000 primary care providers are already needed to alleviate current health professional shortages.

The aging of the nation will be mirrored by the aging of its physicians; over one-third of the current physician workforce is age 55 or older and is likely to retire in the coming decade. However, the number of first-year enrollees in U.S. medical schools per 100,000 people has declined annually over the past 20 years. Consequently, the United States is producing fewer doctors each year relative to our growing and aging population. As a result, the current system relies on physicians educated outside the country, some of whom are U.S. citizens, but most of whom are foreign-born and emigrate to the United States to train and practice. Today, one in four residents-in-training and physicians practicing in the United States attended medical school abroad. In addition to concerns about self-sufficiency in the health professions, U.S. reliance on foreign physicians has been criticized for contributing to the global “brain-drain” of physicians from developing nations challenged by severe health professional shortages of their own.

An acute physician shortage will profoundly affect access to health care, including longer waits for appointments and the need to travel farther to see a physician. Shortages can also contribute to higher costs through increased use of emergency rooms. In addition, physician shortages can reduce the quality of care if practitioners are overloaded or if individuals are forced to delay treatment.

It is important to note that increasing the number of physicians alone will not correct geographic maldistribution, lack of cultural competence in the provision of care, or health care disparities. The nation not only needs more doctors, it needs a more racially and ethnically diverse workforce responsive to and capable of providing optimal care for an increasingly diverse population. Medical students from racial and ethnic minority groups are also more likely to practice in underserved communities and care for a disproportionate number of disadvantaged patients.

In response to these challenges, the AAMC has called for a 30 percent increase in medical school enrollment and a commensurate increase in graduate medical education (GME) training positions. Although medical school enrollment is expected to reach the 30 percent goal by 2016, this expansion will not produce a sufficient number of physicians to serve the nation without growth in GME. In addition, a comprehensive strategy must include increased use of nurse practitioners, physician assistants, and other health professionals while improving efficiency and making better use of physicians' unique knowledge and skills. Health care delivery models will also need to be re-examined to ensure that teams of professionals can



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provide efficient, effective services that improve the health of populations.

Because the education and training of a physician may require a decade or more, the nation must invest in the growth of the physician workforce while it concurrently works to improve the delivery system and achieve a better balance between the health workforce and the needs of the population.

AAMC Policy/Recommendations

- Lift the Medicare resident caps—Since 1998, Medicare has “capped” the number of residents for which the program would provide support for the associated training costs. Achieving an increase in the physician supply requires a lifting of the residency training caps, as well as an increase in medical school enrollment.
- Support lawful race- and ethnicity-conscious medical school admissions policies—Financial aid and admission policies based on a holistic review of applicants will allow medical schools to select students who will further each medical school’s educational goals and meet local health care needs.
- Increase funding for the National Health Service Corps (NHSC) —The number of NHSC awards should be increased by at least 1,500 per year to help more physicians practice in underserved areas while enabling more new physicians to practice primary care.
- Continue to support opportunities for IMGs to train and practice in the United States—The J-1 visa is an educational visa that allows foreign citizens to train in the United States and then to return to their country of origin unless they practice in a federally designated shortage area. J-1 visa waiver programs, such as the Conrad State 30, provide an important opportunity for a limited number of U.S.-trained foreign physicians to practice in federally designated health professions shortage areas. The J-1 visa is the most appropriate visa for non-U.S. medical residents and should be encouraged. Conversely, H-1 visas are work visas and are not appropriate for medical education and training purposes.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Health Professions Education Legislation (Title VII)
- Medical Student Loans
- National Health Service Corps
- Medicare and Teaching Hospitals
- Health and Health Care Disparities
- Primary Care

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Web Resources

www.aamc.org/workforce
www.aamc.org/diversity
www.aspiringdocs.org

Primary Care

Issue

The proportion of U.S. physicians (and other health professionals) choosing careers in primary care—family medicine, general internal medicine, and general pediatrics—has declined significantly over the past decade while Americans continue to have difficulty accessing primary care and preventive services.

Background

Primary care physicians have represented approximately one-third of U.S. physicians for the last half-century, but interest in this group of specialties among new medical school graduates has fluctuated widely as the number of potential specialties to choose from has grown dramatically. The American health system has been criticized for its heavy reliance on subspecialists for more than 30 years, particularly when compared with other industrialized nations that are more primary-care-oriented, have lower health care costs, and better measures of health status such as infant mortality and life expectancy at birth. However, these international comparisons have been confounded because most other industrialized nations also tend to have more preventive care delivered by a robust public health system and are supported by strong social welfare programs.

Despite these criticisms and related attempts to change the specialty composition of the physician workforce for three decades, a lower proportion of U.S. physicians are choosing primary care compared with a decade ago. According to the National Resident Matching Program, the number of U.S. medical school graduates choosing family medicine rose from 1,374 in 1991 to 2,340 in 1997, but decreased to 1,156 in 2008. Subspecialization rates are increasing, particularly among graduates of internal medicine programs, but also within pediatrics, general surgery, and psychiatry. The rise in interest in primary care during the 1990s was concurrent with the national expectation that reimbursement and delivery systems would change to rely heavily on primary care as part of a national trend towards tightly managed care. The fall in interest in primary care (and increase in subspecialization rates) occurred as managed care was falling out of national favor.

Peer-reviewed literature suggests that trends in, and expectations of, the reimbursement and delivery system appear to influence specialty choice, as do debt, lifestyle issues, demographic factors, and personal preferences of

new physicians. Specialty choice decisions among new M.D. and osteopathic graduates also reflect the professional discontent expressed by practicing primary care physicians. Moreover, the rise of subspecialization in medicine is mirrored by that of other professions (law, engineering, etc.) and by the desire of many patients to be seen by a specialist or “expert” in the field.

These factors have made increasing the proportion of primary care physicians more challenging despite three decades of attempts. Small changes in the reimbursement system have not eliminated large income discrepancies between primary care physicians and their subspecialist colleagues, particularly those who derive their income from procedures. Similar differences in income and a decline in interest in primary care have also occurred in the physician assistant profession.

Medical education and training appear to have less impact on specialty choice than the practice environment for primary care. Previous attempts to alter specialty composition have failed when they relied on changes to Medicare’s reimbursement to teaching hospitals that offset some of their graduate medical education (GME) costs. For instance, current Medicare GME payments for resident costs associated with subspecialty training are one-half of reimbursement for physician trainees in their first residency; the exception to this policy is for geriatrics fellowships, which are reimbursed at the full rate. Yet, many training positions remain unfilled in geriatrics, and most physicians will go on to subspecialize despite GME policies that favor primary care.

Current policy proposals to reinvigorate primary care have focused primarily on increasing reimbursement, which history (and international experience) suggests may increase the proportion of physicians entering primary care. However, most scholars concerned about the future of primary care also acknowledge a need to transform the way this care is delivered; this includes increased reliance on non-physician team members and creating a “medical home” for patients that proactively manages individuals and populations. Medicare and several private payers are planning (or already engaged in) medical home demonstration projects that may improve patient and physician satisfaction and will, hopefully, lead to better outcomes at lower costs to the system. The Association of American Medical Colleges (AAMC) is also working with its faculty practice plans to identify ways that medical homes and other delivery innovations can be implemented to improve both delivery and training. Even if these policies and programs are



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successful, changes in specialty choice by new physicians will take years to detect given the long length of training.

AAMC Policy/Recommendations

Specialty choice is highly influenced by the practice environment including reimbursement, scope of practice, prestige, and other factors which affect the satisfaction of physicians. The AAMC and its members are committed to creating an environment where primary care and the multiple missions of medical schools and teaching hospitals can flourish.

- The AAMC endorses the medical home model of care delivery and recognizes the need to examine how the model can best be measured and operationalized.
- Payment policies must fairly reflect the cost and effort of the components of the medical home, including care coordination, prevention, and chronic care.
- GME reimbursement policies must allow teaching hospitals and residency programs more flexibility by lifting regulations that penalize training in non-hospital settings (e.g., nonreimbursement for didactic time and allowing voluntary supervision of residents).
- The number of NHSC awards should be increased by at least 1,500 per year to help more new physicians practice primary care and serve underserved populations.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Medicare and Teaching Hospitals
- Medicare Physician Payments
- Medical Home
- National Health Service Corps
- Physician Workforce Issues

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Web Resources

Position Statement on the Medical Home,
www.aamc.org/patientcare/newmodels

National Institutes of Health

Issue

The partnership between the National Institutes of Health (NIH) and America's medical schools and teaching hospitals, forged in the aftermath of World War II, continues to serve as the driving force in the nation's search for ever-deeper understanding of the mechanisms of human health and disease, from which arise new diagnostics, treatments, and cures, and better ways to improve health and save lives. Since completion of the NIH doubling between fiscal years (FY) 1999 and 2003, the NIH budget has stagnated, impeding basic research, stalling the search for cures, and threatening the long-term viability of the medical research enterprise.

Background

Medical schools and teaching hospitals sustain an environment where basic, clinical, and health services research can flourish alongside clinical care and training. The NIH helps sustain and advance this important synergy of the missions of medical schools and teaching hospitals.

With an annual budget of about \$29 billion (FY 2008), the NIH is the primary source of federal funding for medical research. NIH research funding is divided between intramural research (conducted by NIH employees at NIH facilities) and extramural research (mostly conducted by academic faculty and others at medical schools, teaching hospitals, and independent research institutes). The NIH budget is divided among the following categories (FY 2008 enacted):

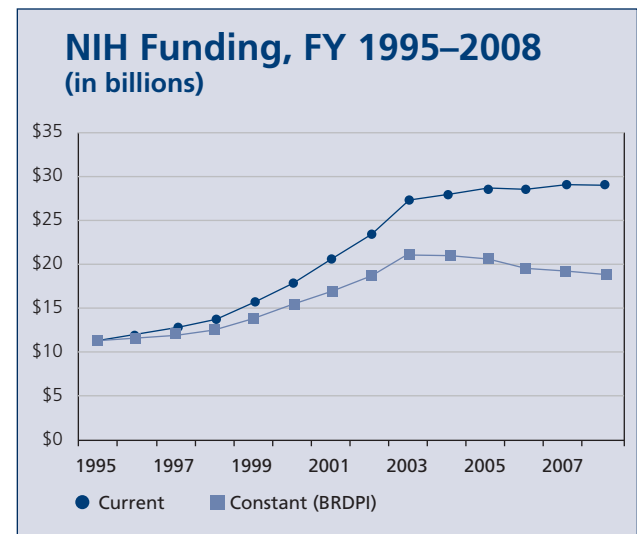
Research Project Grants	53 percent
R&D Contracts	11 percent
Intramural Research	10 percent
Research Centers	10 percent
Other Research	6 percent
Research Management and Support	5 percent
Research Training	3 percent
All Other	2 percent

In 2006, the NIH invested about \$13 billion in research at U.S. medical schools and teaching hospitals, supporting the work of distinguished physicians and scientists. These researchers apply for NIH funding through an intensely competitive peer-review process that funds only the most promising and highest-quality research. Today, the NIH

receives more than 40,000 research project grant applications a year, with less than one in five receiving support through its extramural research program. The NIH's extramural research portfolio is distributed as follows (FY 2006 actual):

Medical Schools and Teaching Hospitals	56 percent
Research Institutes	10 percent
Other Higher Education	22 percent
Other (including industry)	11 percent

Funding the NIH budget, and thus the support it provides to the nation's leading researchers in an environment of clinical excellence, is a critical priority for the new administration. With bipartisan support, the NIH budget doubled in the period FY 1999-2003. However, the Bush administration's FY 2009 proposal represents the sixth consecutive year that the proposed budget for the NIH has failed to keep pace with biomedical inflation (known as the BRDPI). In that period, a combination of nominal increases and cuts has resulted in a stagnant budget that has resulted in a more than 10 percent decline in the agency's purchasing power, and has undermined the strengthened research potential and accomplishments enabled by the doubling.



This flat federal support for the NIH means that important research on many challenges to the health of the nation—including cancer, childhood asthma, vision and hearing loss, mental illnesses, and alcoholism—has been slowed or halted. Fewer than 20 percent of new research proposals are funded, discouraging new scientists from fulfilling their role as the next generation of our research workforce. The scientific pipeline is in serious danger of breaking as younger investigators find it ever harder to win grants to explore their new ideas. Without a strong and sustained investment in NIH research, scientific discovery will slow and patients will wait longer for new treatments and cures, and, indeed, for new hope.

Over the past 30 years, the nation's investment in medical research through the NIH amounts to about \$44 per American per year. But the return on this investment has been truly spectacular. Life expectancy has increased; deaths from heart disease, cancer, and stroke are declining; and new treatments have virtually eliminated transmission of the HIV virus from mother to child. Yet today, spending on treatment of disease and disability far exceeds spending on prevention or cures. In 2007, total U.S. health care spending (\$2.3 trillion) was nearly 80 times the NIH budget.

AAMC Policy/Recommendations

For FY 2009, the Association of American Medical Colleges (AAMC) joined medical research advocacy groups and coalitions in urging further predictable, regular expansion of the nation's investment in medical research. The medical community urged an increase of the NIH budget of \$1.9 billion in FY 2009. This recommendation would increase the NIH's budget by a modest 6.6 percent, permitting the world's preeminent medical research enterprise to reinvigorate the momentum of discovery to improve the health and quality of life for millions.

The AAMC has worked closely with the NIH and scientific community to recommend policy and processes changes to achieve a more effective, streamlined, and fair peer-review system.

- AAMC comments on the NIH self-study of the peer review processes and funding decisions:

www.aamc.org/advocacy/library/research/corres/2007/090607.pdf

www.aamc.org/advocacy/library/research/corres/2008/031708.pdf

www.aamc.org/advocacy/library/research/corres/2008/031708a.pdf

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Research Training
- Conflicts of Interest in Research and Education
- Stem Cell Research and Regenerative Medicine
- Responsible Use of Animals in Research and Education

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Health Professions Education Legislation (Title VII)

Issue

The Title VII and VIII training programs of the Public Health Service Act are the only federal programs with the stated goal of training providers in interdisciplinary settings to improve the supply, diversity, and distribution of the health professions workforce. Despite existing and projected provider shortages (and repeated calls for interdisciplinary care and training) across health professions disciplines, Title VII programs sustained a 51.5 percent funding cut in fiscal year (FY) 2006 and remain woefully underfunded, undermining their ability to meet the needs of special and underserved populations, as well as to increase minority representation in the health care workforce.

Background

Title VII authorizes the health professions education and training programs administered by the Health Resources and Services Administration (HRSA). Through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and nonprofit organizations, these programs support the education and training of the full range of all health care providers, including physicians, dentists, pharmacists, nurses, psychologists, and public and allied health professionals.

Designed to improve the supply, diversity, and distribution of the health care workforce, Title VII programs pick up where traditional market forces leave off. For example, the Title VII diversity programs increase minority representation in the health professions by strengthening the pipeline to a health career. Similarly, the primary care medicine and dentistry programs expand the primary care workforce, while the interdisciplinary, community-based linkages programs facilitate training in rural and urban underserved areas.

Together with Title VIII nursing education programs, health professions programs are a critical component of the health care safety net, training a diverse supply of health professionals who are more likely to serve in community health centers and other rural and urban underserved settings.

As a result of a 51.5 percent funding cut in FY 2006, many Title VII programs were forced to cease their activities. Despite modest increases for some Title VII programs in FYs 2007 and 2008, funding levels for all Title VII programs remain below FY 2005 levels. For example, the Title VII Health Careers Opportunity Program (HCOP) and Centers of Excellence (COE) Diversity programs received a combined \$22.6 million in FY 2008, compared to a combined \$69.3 million in FY 2005. Additionally, the component of Title VII tasked with the compilation and analysis of national health workforce needs and shortages—the Workforce Information and Analysis program—has received no funding since FY 2006. The elimination of funding for this component is especially ironic because the Office of Management and Budget has repeatedly criticized that Title VII “lacks data to demonstrate progress.”

AAMC Policy/Recommendations

As the new administration works to improve health care access for an increasingly diverse nation, it will be essential to ensure that a diverse, well-trained health care provider workforce is in place to meet the additional demand. With its emphasis on diversity, primary care, and special and underserved populations, continued and increased support for the Title VII programs is critical to any comprehensive federal health care workforce strategy.

As a founding member of the Health Professions and Nursing Education Coalition (HPNEC), the AAMC recommended \$550 million for the Title VII and Title VIII health professions and nursing programs in FY 2009. Specifically, the AAMC continues to recommend the restoration of funding for the Title VII programs to at least the FY 2005 level of \$300 million.

Additionally, the AAMC supports the continuation and reauthorization of the Title VII programs with improvements to enhance the productivity and accountability of the programs. Among the AAMC's recommendations for reauthorization:

- An increased authorization level for the six regional workforce centers and the creation of a new national workforce database to track the location of health professionals educated and trained in programs receiving Title VII support.



Policy Priorities to Improve the Nation's Health

- A new structure for the primary care programs in which grants are preferentially awarded to applicants who enter into a formal relationship and submit a joint application with a Federally Qualified Health Center (FQHC), an FQHC Look-Alike, an Area Health Education Center (AHEC), or a clinic located in a Health Professions Shortage Area (HPSA) or Medically Underserved Area (MUA), or a clinical practice setting in which at least 40 percent of its patients are either uninsured or supported by Medicaid.
- The creation of a new program to support demonstration projects designed to increase the number of underrepresented minority faculty.
- The creation of a new program awarding grants to schools or departments to administer demonstration projects centered on improving the quality of primary care in selected emphasis areas.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Health and Health Care Disparities
- Other Priority Health and Research Agencies
- Primary Care

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Veterans Health System: Education

Issue

The affiliations between the Department of Veterans Affairs (VA) medical centers and the nation's medical schools have provided a critical link that trains new physicians and brings expert clinicians and researchers to the VA health system. As the nation faces a serious physician shortage, it is very important for the VA to restore its graduate medical education (GME) program to historical levels and increase recruitment incentives to attract new physicians to the VA.

Background

Over six decades, VA-medical school affiliations have proven to be mutually beneficial by sharing experiences and access to resources that would otherwise be unavailable. It would be difficult for the VA to deliver its high-quality patient care without the physician faculty and medical residents who are available through these affiliations. In return, medical schools ensure their educational opportunities are expanded to include care of the nation's veterans through student rotations and residency positions at VA hospitals.

At present, 130 VA medical centers have affiliations with 107 of the 130 U.S. medical schools. The VA manages the largest GME training program system in the United States. The VA system supports approximately 9 percent of all GME positions in the country, including more than 2,000 Accreditation Council for Graduate Medical Education (ACGME)-accredited programs and 9,000 residency training positions. Each year, approximately 34,000 residents (30 percent of total) rotate through the VA system, and more than half the nation's physicians received some part of their medical education and training in VA hospitals.

As the nation faces a shortage of physicians, the VA has been the first to respond. The VA is increasing its support for GME training through the VA GME enhancement initiative, adding an additional 2,000 residency training positions over five years, returning VA-funded medical resident positions to between 10 and 11 percent of GME in the United States. The expansion began in July 2007 when the VA added 342 new positions. These training positions address the VA's critical needs and provide skilled health care professionals for the entire nation. The additional residency positions also encourage innovation in education that will improve patient care, enable physicians in different disciplines to work together, and incorporate state-of-the-art models of clinical care—including VA's

renowned quality and patient safety programs and electronic medical records system.

In some cases, the VA has had difficulty recruiting health professionals, similar to the problems recruiting providers for some rural and urban areas, population groups, or medical facilities designated as underserved by the U.S. Department of Health and Human Services. The VA's Education Debt Reduction Program (EDRP) provides newly appointed VA health care professionals with educational loan repayment awards. However, the EDRP is limited to \$49,000 spread out over five years of service. As the median medical education indebtedness has climbed to over \$155,000 in 2008, the limited EDRP awards fail to provide an adequate incentive for most physicians to participate in the EDRP.

AAMC Policy/Recommendations

The Association of American Medical Colleges (AAMC) supports the VA GME Enhancement Initiative consistent with the September 2005 recommendations of the Advisory Committee on Veterans Health Administration Resident Education that encouraged the VA to restore and maintain its historic support for approximately 11 percent of the total U.S. resident physician positions.

The AAMC also recommends increasing VA physician educational loan repayments in exchange for a period of service in hard-to-fill positions, as determined by the VA. Under this program, VA physicians should be eligible for loan forgiveness each year until their medical education debt has been repaid.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Veterans Health System: Research

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Medical Student Loans

Issue

The cost of medical education can discourage prospective students from applying to medical school, making efforts to expand and diversify the workforce more challenging. The average debt incurred by medical students also can affect career choice, discouraging new physicians from choosing careers in primary care and other specialties with lower incomes.

Background

In 2008, 87 percent of U.S. medical students graduated with debt, and the average indebtedness was \$155,000—one of the highest levels of any profession. Part of this large debt burden is due to the length of schooling and additional training new physicians must complete, as well as the costs of medical education and the facilities and faculty it requires.

The U.S. Department of Education offers subsidized and unsubsidized Stafford loans for graduate/professional students (including medical students) that have better terms and conditions than any other source of loan capital. Both the subsidized and unsubsidized Stafford loans carry a fixed 6.8 percent interest rate. Students are not required to make payments on either loan while in school, and the government pays the interest on subsidized Stafford loans during that period.

Subsidized Stafford loans for graduate/professional students are limited to \$8,500 annually and \$65,500 in total (including undergraduate subsidized Stafford loans). Unsubsidized Stafford loans for health professions students are limited to \$32,000 annually. In total, health professions students may borrow up to \$224,000 in subsidized and unsubsidized Stafford loans over the course of their academic career.

Because of the variability in tuition and costs of living, many medical students already exceed the annual and aggregate limits for federal Stafford education loans. GradPLUS loans allow students to obtain federal educational loans up to the total cost of attendance, but are unsubsidized and carry a much higher 8.5 percent interest rate.

Private loans have uncapped interest rates and less flexibility for deferment and forbearance. Limiting exposure to private loans and increasing the portion of subsidized loans will help ensure that medical education is affordable for students from all backgrounds.

AAMC Policy/Recommendations

Subsidized annual loan limits have not been raised since the 1992 Higher Education Act reauthorization. To ensure that students from all backgrounds can afford medical education, the Association of American Medical Colleges (AAMC) recommends increasing the current annual subsidized Stafford loan limit for graduate/professional students from \$8,500 to at least \$12,000. Accordingly, the AAMC also recommends increasing the aggregate subsidized Stafford loan limit for graduate/professional students from \$65,500 to at least \$79,500.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Health Professions Education Legislation (Title VII)
- National Health Service Corps
- Primary Care

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National Health Service Corps

Issue

The National Health Service Corps (NHSC) Scholarship and Loan Repayment programs have proven to provide successful incentives for recruiting health professionals to underserved areas. However, recent funding cuts have resulted in a decrease of annual NHSC awards and overall NHSC field strength, even though the Health Resources and Services Administration (HRSA) estimates that an additional 30,000 practitioners are needed. As of June 2008, the HRSA estimates that 63 million people live in federally designated primary care health professions shortage areas (HPSAs).

Background

An appropriate supply of well-educated and trained physicians is essential to assure access to quality health care services for all Americans. The United States is facing a physician shortage due to the nation's rapidly growing population, increasing numbers of elderly Americans, an aging physician workforce, and a rising demand for health care services. This shortage puts additional strain on the approximately 20 percent of the U.S. population already residing in HPSAs. The NHSC Scholarship and Loan Repayment programs help address geographic maldistribution, lack of cultural competence in the provision of care, and health care disparities by recruiting individuals who are more likely to practice in underserved communities, but their impact is limited by relatively low funding levels when compared with national need.

The NHSC Scholarship Program pays qualifying tuition and fees along with a monthly stipend; the NHSC Loan Repayment Program repays qualifying medical education debt for health professionals who commit to practice in a HPSA for a minimum of two years. Since 1997, median indebtedness for U.S. medical school graduates has increased by 75 percent. In 2008, 87 percent of U.S. medical students graduated with an average indebtedness of \$155,000. The growing debt of graduating medical students will increase their interest and willingness to apply for NHSC awards to alleviate this financial burden through scholarship and loan repayment opportunities.

While the NHSC supports a field strength of more than 4,000 practitioners, HRSA estimates that an additional 30,000 practitioners are needed to achieve the target HPSA practitioner/population ratios. In the past five years, funding for the NHSC has been cut by more than \$47 million, a 27 percent reduction from the \$171 million fiscal year (FY) 2003 budget that was already insufficient to meet the nation's needs. As a result, the NHSC has reduced the number of new annual scholarship and loan repayment awards by more than 45 percent during that period (from 1,351 awards in FY 2003 to 730 in FY 2008). At its current funding level, the NHSC is unable to award all qualified scholarship applicants, and 13 students are turned away for every one accepted. Similarly, twice as many applicants are seeking loan repayment than are accepted.

AAMC Policy/Recommendations

The Association of American Medical Colleges (AAMC) supports increasing the number of NHSC awards by at least 1,500 per year to help encourage more physicians to practice in underserved areas. To address recent funding deficiencies, the AAMC recommends a steady and sustainable increase in the NHSC appropriations starting with \$200 million for FY 2009.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Health Professions Education Legislation (Title VII)
- Medical Student Loans
- Primary Care

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Resident Duty Hours

Issue

After completing four years of medical school, new physicians must undergo between three and eight additional years of clinically based education to become fully licensed and eligible for board certification in a specialty. As residents, these students receive world-class education that the nation expects. Their duty hours should ensure resident well-being and patient care safety, both during training and throughout their careers as practicing physicians.

Current duty hours are limited by the Accreditation Council for Graduate Medical Education (ACGME), the body responsible for accreditation of GME training; however, Congress and others have repeatedly called for further limitations.

Background

Residents are physicians in post-M.D. programs designed to provide them the skills and knowledge to practice competently and independently. Some residency education is required for a physician to be licensed in all states, and completion of an accredited residency program is a prerequisite for certification by a specialty board and a de facto requirement to provide service in almost any hospital. During this part of their educational continuum, residents are simultaneously learners and providers of medical service to patients. Historically, they devoted very long hours to their learning and service responsibilities. In 2003, the ACGME established requirements for all accredited programs that limit duty hours for residents to 80 hours per week averaged over four weeks, with continuous duty not to exceed 24 hours (with up to six hours of transition), overnight duty (“call”) limited to one night in three, one full day free of duty in each seven-day period, and 10 hours free between duty periods. As a corporate member of the ACGME, the Association of American Medical Colleges (AAMC) participated in the deliberations that led to these common requirements. The AAMC sponsored conferences in 2002 and 2003 to help its member hospitals and medical schools—which educate most residents—understand and implement these requirements.

While ACGME surveys of residents have shown very high rates of compliance with these requirements (only 8.8 percent of programs were cited for violations between July 2003 and December 2007), some violations continue to occur and questions are sometimes raised about the efficacy of the ACGME in setting and enforcing resident duty hours to preserve resident well-being and patient safety. In 2007, the Institute of Medicine (IOM) established a committee on “Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety” charged to synthesize the available evidence and suggest “strategies to enable optimization of work schedules to improve safety in the health care work environment.” The committee report was released on December 2, 2008.

Since 1988, the AAMC has been on record favoring reasonable and flexible limits on resident hours. Twenty years later, in its testimony to the IOM committee on May 8, 2008, the AAMC observed that resident duty hours are not a stand-alone issue but are part of a matrix of tightly interrelated issues that influence the educational value of training programs. These interdependent issues include the quality of the educational program, the supervision of residents’ patient care activities, institutional support and oversight of GME, the quality of patient care, and patient care staffing and processes. The AAMC believes that resident schedules and duty hours can be addressed meaningfully only by considering all these issues.

Limited evidence exists for determining what an ideal limit is on resident hours and the potential unintended consequences of further changes, both on residency education and patient care. Because the current duty hour restrictions were implemented only five years ago, further studies are only now becoming feasible.

AAMC Policy/Recommendations

The AAMC opposes any legislative or regulatory effort to limit resident duty hours.

As the accrediting agency, the ACGME is the appropriate body to establish, monitor, and enforce resident duty hours, as the council not only represents all the key stakeholders but also is cognizant of both the educational and patient care implications of duty hour rules. The AAMC recommends that additional research be conducted to strengthen the basis for possible future decision making about resident hours and work schedules.



Policy Priorities to Improve the Nation's Health

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Health Care Quality

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2008/050808.pdf](http://www.aamc.org/advocacy/library/teachhosp/testimony/2008/050808.pdf)
www.aamc.org/patientcare/gmepolicy/gmepolicy.pdf

Conflicts of Interest in Research and Education

Issue

An effective and principled partnership between medical schools and teaching hospitals and various health industries is essential to realize fully the benefits of biomedical research and ensure continued advances in preventing, diagnosing, and treating disease. Appropriate management of this partnership by medical schools and teaching hospitals is crucial to ensure that it remains principled and capable of sustaining public trust in the proposition that academic medicine is fundamentally dedicated to the welfare of patients and the improvement of public health.

Background

The vitality and integrity of biomedical research are critical to the health of the public and to finding solutions to some of society's most compelling and difficult health challenges. In the United States, universities and medical schools—the dominant sources of this research—are now, more than ever, essential parts of the social, economic, and scientific forces that empower nations in a global world.

The Bayh-Dole Act of 1980 accelerated a shift in roles for academic institutions by allowing faculty and institutions to retain title to the intellectual property resulting from their federally supported research and by encouraging them to promote the commercial development of their discoveries through technology licensing. There can be no doubt that Bayh-Dole has been an unparalleled success in speeding discoveries from the laboratory to the marketplace, resulting in great social benefit.

The benefits of Bayh-Dole and the broader roles of the academic community have come with some potential downsides, however, and the risks to the integrity of the research and education missions of academic institutions and to their faculty in this new paradigm are decidedly higher. Expanded and deepened relationships with industry may involve financial linkages that are entirely benign but will, in other cases, carry the potential to create serious conflicts of interest. Moreover, these financial ties are occurring in a context of dramatically increased public sensitivity to, and concern with, allegations of financial conflicts of interest more broadly in university business transactions, in the medical profession, and across diverse sectors of industry.

In recognition of these changing circumstances, both the federal government and the academic community have been active in defining their respective responsibilities to assure the integrity of these relationships between academe and industry in research. The federal government has regulated financial conflicts of interest in federally sponsored research since 1995, and has deferred the responsibility to recipient institutions to identify and manage or eliminate such conflicts in this research. Recognizing that this deference rests critically on the trustworthiness and accountability of academic institutions, the Association of American Medical Colleges (AAMC) issued strong recommendations in 2001 and 2002 addressing individual and institutional financial conflicts of interest in research.

Based on experience with the regulations and its own recommendations as well as the experiences within the National Institutes of Health (NIH) involving financial conflicts of interest, the AAMC and the Association of American Universities (AAU) undertook during 2007 and early 2008 an intense review and expansion of the associations' previously issued guidance on conflicts of interest.

The same societal forces that have expanded relationships between academic medicine and industry in the research realm have also affected medical education. Medical schools and teaching hospitals have become increasingly dependent on industry support of their core educational missions. This reliance raises concerns because such support can influence the objectivity and integrity of academic teaching, learning, and practice, thereby calling into question the commitment of academia to promote the most patient-centric, evidence-based medical care possible. To address the challenges posed by this dependence, an AAMC task force forged consensus principles, issued early in 2008, to guide the leaders of medical schools and teaching hospitals in developing policies and procedures to manage industry gifting practices and financial support of their programs of medical education for students, trainees, faculty, and community physicians.

AAMC Policy/Recommendations

The AAMC supports the provisions of the “Physician Payments Sunshine Act” (S. 2029), introduced by Senators Chuck Grassley (R-Iowa) and Herb Kohl (D-Wis.), which would require drug, device, or medical supply manufacturers receiving federal payments to disclose anything of value given to doctors, such as payments, gifts, honoraria, or travel awards.



Policy Priorities to Improve the Nation's Health

In biomedical research, the AAMC strongly advocates the adoption of more consistently stringent policies and practices across academic institutions and further asserts that time is of the essence with respect to implementing fully comprehensive conflicts of interest programs in human subjects research.

In medical education, the AAMC acknowledges the new policy directions being implemented in many medical schools and teaching hospitals to circumscribe industry support of medical education. The AAMC is urging all medical schools and teaching hospitals to accelerate their adoption of AAMC-recommended policies that better manage—and when necessary, prohibit—academic-industry interactions that can inherently create conflicts of interest and undermine standards of professionalism.

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www.aamc.org/advocacy/library/teachphys/corres/2008/050208.pdf

Veterans Health System: Research

Issue

The Department of Veterans Affairs (VA) Medical and Prosthetic Research program supports one of the nation's premier research endeavors and attracts high-caliber clinicians to deliver care and conduct research in VA health care facilities in close collaboration with Association of American Medical College's (AAMC) members. Increased funding for VA research is crucial to the continued success of the primary sources of VA's physician recruitment and retention: academic affiliations, graduate medical education, and research.

Background

The VA's organizational mission states that it needs to provide "excellence in research," and must be an organization characterized as an "employer of choice." The VA research program is exclusively intramural; that is, only VA employees holding at least a five-eighths salaried appointment are eligible to receive VA awards. Unlike other federal research agencies, the VA does not make grants to any non-VA entities. As such, the program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health care system to the benefit of veteran's health care.

The VA currently supports 5,143 researchers, of which nearly 83 percent are practicing physicians who provide direct patient care to veterans. As a result, the VA has a unique ability to translate progress in medical science directly to improvements in clinical care. VA research awards are typically three to five years in duration. However, scientific advancement can entail many more years and requires steady, sustainable funding. Maintaining current levels of VA research activity will require increases in funding of at least \$20 million in each of the next three federal fiscal years.

Additional funding will be needed to expand research to meet the evolving health care needs of veterans participating in Operation Enduring Freedom and Operation Iraqi Freedom. Improvements in prosthetics and rehabilitation, as well as better treatments for polytraumas, traumatic brain injury (TBI), whole body burns, and post-traumatic stress disorder (PTSD) are urgently needed. In addition, as the largest integrated health care system in the world with an industry-leading electronic health record system and a dedicated treatment population for sustained research, the VA is in a unique position to revamp modern health care

and to provide progressive, cutting-edge care for veterans through genomic medicine. The VA combines these attributes with high ethical standards and standardized processing that are leading to innovations in safer, more accurate, and personalized treatment and prevention with genomic medicine

State-of-the-art research requires state-of-the-art technology, equipment, and facilities. Such an environment promotes excellence in teaching and patient care as well as research. It also helps the VA recruit and retain the best and brightest clinician scientists. In recent years, funding for the VA medical and prosthetics research program has failed to provide the resources needed to maintain, upgrade, and replace aging research facilities. Many VA facilities have run out of adequate research space. Ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. Under the current system, research must compete with other facility needs for basic infrastructure and physical plant support that are funded through the minor construction appropriation.

AAMC Policy/Recommendations

Funding for VA research must be steady and sustainable to allow for innovative scientific growth to address critical emerging needs.

As a member of the executive committee of the Friends of VA Medical Care and Health Research (FOVA) coalition, the AAMC recommends an FY 2010 appropriation of \$575 million for the VA Medical and Prosthetic Research program. The FY 2009 Military Construction and Veteran Affairs Appropriations Act included \$510 million for VA research.

The AAMC also recommends funding for additional major construction to replace at least one outdated facility per year to address the critical shortage of research space, and a new annual appropriation dedicated to renovating existing research facilities, beginning with \$142 million in FY 2010.



Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Veterans Health System: Education
- National Institutes of Health

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Stem Cell Research and Regenerative Medicine

Issue

Human embryonic stem cells are unique in that they can develop into vastly different cell types. As a result, they may offer a renewable source of replacement cells to treat diseases, conditions, and disabilities. Under current federal policy, federal funds may only be used on research involving the 21 embryonic stem cell lines derived before August 9, 2001. Hundreds of stem cell lines are now available, but cannot be used in federally funded research. The AAMC strongly believes an expanded federal stem cell policy is necessary.

Background

Stem cells are believed to have the ability to divide without limit and to give rise to daughter cells that can form specialized cells. These cells can be categorized as “pluripotent,” meaning they are capable of specializing into many (but not necessarily all) tissues of an organism; or “totipotent,” which have unlimited ability to differentiate into all tissues and organs.

Human embryonic stem cells were first isolated in 1998 by scientists at the University of Wisconsin and Johns Hopkins University. These discoveries have raised a number of ethical and legal issues. Under language included in the annual Labor-HHS Appropriations bill since 1996, the federal government is prohibited from funding research involving human embryos. In January 1999, the general counsel of the Department of Health and Human Services (HHS) determined that the federal government was not prohibited from funding research utilizing human pluripotent stem cells based on the scientific determination that stem cells are not “organisms” and therefore cannot be considered human embryos. However, federal funding of stem cell derivation activities was judged to be prohibited.

Soon after taking office in early 2001, President George W. Bush ordered a review of the January 1999 legal determination by HHS that permitted the use of federal funds to support research utilizing human embryonic stem cells. Subsequently, HHS Secretary Tommy Thompson asked NIH to provide him with a report on the scientific issues involved in stem cell research.

On August 9, 2001, President Bush announced that federal funds could be awarded for research using human embryonic stem cell lines that meet certain criteria. Such research is now eligible for federal funding as long as the derivation process was initiated prior to 9:00 p.m. EDT on August 9, 2001. Currently, only 21 human embryonic stem cell lines meet the eligibility criteria set by President Bush on August 9, 2001.

Since the president’s announcement, the NIH has funded various research and training grant applications using the eligible stem cell lines. On such activities, the NIH reports that it spent \$20 million in fiscal year (FY) 2003, \$24 million in FY 2004, \$40 million in FY 2005, \$38 million in FY 2006, \$42 million in FY 2007, an estimated \$42 million in FY 2008, and will spend a projected \$42 million in FY 2009. By comparison, in FY 2009, NIH estimates it will spend \$203 million in nonembryonic human stem cell research. The NIH also has funded an internal stem cell laboratory.

Since President Bush’s 2001 policy announcement, numerous bills have been introduced in Congress concerning stem cell research. The 109th and 110th Congresses passed legislation to expand the President’s policy and allow funding of all stem cell lines that met ethical guidelines mandated by the legislation. Both bills were vetoed by President Bush.

Induced pluripotent stem cells (iPS) are a type of stem cell artificially derived from a nonpluripotent cell. Induced pluripotent stem cells are believed to be similar to natural pluripotent stem cells, such as embryonic stem cells. iPS cells were first produced in 2007 from human cells and are considered an important advancement in stem cell research, as they may eventually allow researchers to obtain pluripotent stem cells without the controversial use of embryos. However, most scientists still believe that embryonic stem cells are the most promising. Harvard University’s Dr. George Daley recently called them the “gold standard” and said, “At least for the foreseeable future—I would argue forever—they’re going to be extremely valuable tools.”

AAMC Policy/Recommendations

The AAMC strongly supports federal funding of human embryonic stem cell research.

The association also concurs with the January 1999 legal determination of the Department of Health and Human Services that current law permits the use of federal funds to support research utilizing human pluripotent stem cells.



Policy Priorities to Improve the Nation's Health

The AAMC is a charter member of the Coalition for the Advancement of Medical Research (CAMR). The coalition is composed of universities, scientific societies, patient organizations, and other entities devoted to ensuring that federal funding will be available for stem cell research.

In 2003, the AAMC urged the National Research Council and the Institute of Medicine to develop guidelines for the responsible practice of human embryonic stem cell research, which were released in April 2005. Some revisions to the guidelines were released in early 2007 and in September 2008.

On April 27, 2006, the AAMC sponsored a workshop to consider institutional compliance issues related to stem cell research. A summary report on the workshop is available online at www.aamc.org/stemcellchallenges

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Research Training

Issue

The ability to maintain a productive, innovative, and multidisciplinary scientific and medical research workforce depends on the success of academic institutions in training, recruiting, and retaining talented and dedicated scientists. Research careers must remain an attractive and viable career option for young physician (M.D. or M.D.-Ph.D.) and biomedical (Ph.D.) scientists.

Background

More than 7,000 doctorate degrees (Ph.D.'s) in biological and medical sciences are earned annually at U.S. institutions. More than half of these degrees are awarded to students studying at U.S. medical schools. Students generally receive tuition support, benefits, and stipends throughout their graduate training. More than 100 dual-degree (M.D.-Ph.D.) training programs, of which 42 are currently funded by the National Institutes of Health (NIH) Medical Scientist Training Program (MSTP), produce more than 500 M.D.-Ph.D. graduates each year. Biomedical Ph.D. graduate training is mainly supported through the NIH and other federal research grants, fellowships, and traineeships as well as from institutional funds. Extensive postdoctoral training is often necessary to gain the full complement of skills required for independent research and is now an integral component of the preparation of scientists as they advance in their work and careers.

Over the last 40 years, the number of students supported through federal research grants and fellowships has almost tripled. However, the NIH training budget and stipend levels have remained largely flat since 2004. In response to a report from the National Research Council on "Addressing the Nation's Changing Needs for Biomedical Scientists" (2000), the NIH in 2001 planned to develop budget requests that would increase stipends for graduate students and postdoctoral trainees supported under the National Research Service Award (NRSA) over several years to reach an identified target and to subsequently provide cost-of-living increases each year thereafter. The NIH was unable to fund these planned increases.

The number of postdoctoral trainees has expanded rapidly, largely due to an increase in non-U.S. citizen trainees. These non-U.S. citizen trainees are ineligible for NIH training awards but are an important component of sustaining the leadership of U.S. institutions in research and discovery and are sometimes funded as part of research project budgets.

As the number of Ph.D.-level biomedical scientists has increased, it has become far more difficult to obtain permanent academic positions. As a result, the average age at which scientists receive a first medical school faculty appointment and first federal independent research award is increasing. In a time of stagnant NIH funding, this environment has led to many students becoming discouraged about the prospects for entering research careers.

Physician scientists wanting to pursue translational and clinical research careers face some unique challenges. Unlike Ph.D. trainees, the training pathway for physician clinical and translational researchers is not as clearly defined. However, there are promising signs of more prominent early, well-structured training in basic science and clinical research in medical school curricula that includes the option to take one or more years to complete research projects, usually leading to dual degrees (M.D.-Ph.D., M.D.-M.S.). The risk remains that new physician scientists who have been encouraged to pursue academic research careers will be unable to secure funding from the NIH and will be drawn to more stable, well-paid nonresearch job opportunities in private practice, thus decreasing the small pool of trained clinical researchers.

Maintaining a diverse academic research workforce continues to be a challenge. Although they comprise half of U.S. medical students and new biomedical Ph.D.'s, women continue to be underrepresented in the academic research workforce. Minority scientists continue to be significantly underrepresented in both the training pipeline and academic research workforce as well. Close collaboration between Association of American Medical Colleges (AAMC) member institutions, the NIH, and other stakeholders in examining existing biomedical and physician scientist training tracks, and identifying and analyzing the causes of attrition (i.e., prolonged training, debt-load, inadequate research funding, protected research time, insufficient mentorship) is essential for developing strategies to promote a more diverse and vibrant research workforce.



AAMC Policy/Recommendations

The federal government must expand funding for the NIH and other Department of Health and Human Services (HHS) agency grants to strengthen the research workforce. Sustained growth in the NIH budget would permit increases in the training budget and stipend levels.

The AAMC and its member institutions strongly support high-quality education and training that includes supportive mentoring, effective career guidance, adequate financial support, and cultivation of relevant skills being made available to all graduate students and postdoctoral scholars. This support includes:

- Endorsement of AAU Report on Postdoctoral Education (including a uniform definition of postdoc) www.aamc.org/members/great/AdvisoryMemo99-77.pdf
- AAMC and FASEB Statement on Health Benefits for Postdoctoral Researchers www.aamc.org/advocacy/library/research/testimony/2006/101706.pdf
- Compact Between Postdoctoral Appointees and Their Mentors www.aamc.org/research/postdoccompact

In 2006, the AAMC governance accepted the report and recommendations of the Task Force II on Clinical Research to medical schools and teaching hospitals on how to best recruit, train, and sustain clinical and, especially, translational physician-scientists.

- AAMC Task Force II on Clinical Research www.aamc.org/promotingclinicalscience

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- National Institutes of Health
- Conflicts of Interest in Research and Education
- Health and Health Care Disparities
- Medical Student Loans

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Privacy in Research and Health Care Delivery

Issue

The unintended negative consequences of the privacy rule to implement the Healthcare Insurance Portability and Accountability Act (HIPAA) have had a significant impact on biomedical research and on health care operations, and have added significant burdens, impediments, and/or costs to the research and patient care carried out by medical schools and teaching hospitals. Further privacy regulations, if not carefully implemented, may impede the ability of teaching hospitals, physicians, and medical schools to advance research and improve the quality of care.

Background

Association of American Medical Colleges (AAMC) members conduct much of the nation's biomedical and behavioral research, and share a profound interest in protections for research participants, including protections for the privacy of individual volunteers for research and the confidentiality of research data. However, the features of the final privacy rule have not adequately protected essential research activity on which the health and well being of all members of the public depends, nor have they added marginally to protection of privacy and confidentiality of medical information.

The final privacy rule required changes in well-established, highly regulated research methods and processes. The changes consisted of a regulatory apparatus for which there has not been a corresponding gain in patient privacy protection. Population-based research (i.e., epidemiological, health services, environmental, and occupational health research) is especially affected in that such research requires broad, unbiased access to medical records of community health care providers as well as of medical schools and teaching hospitals. Long-term medical outcomes research and registry research also are negatively affected, and registry research is essential to informed analysis of many disease states.

Privacy concerns are also warranted in any discussion of the use of health information technology (HIT) in health care. However, privacy and other concerns expressed by policymakers and the public have led to the introduction of a series of bills that could have a far-reaching impact on the daily operations of teaching hospitals and health systems; many would impede ongoing efforts to improve the quality

of health care delivered at AAMC-member institutions. The association is particularly concerned with measures requiring health providers using electronic medical records (EMRs) to obtain "consent" for uses and disclosures of protected health information for "health care operations," as defined by the HIPAA privacy rule.¹

The AAMC remains committed to ensuring that patients' privacy and protected health information remains secure.

The AAMC, through invited testimony to the National Committee on Vital and Health Statistics (NCVHS) and to the Department of Health and Human Services (HHS) Secretary's Advisory Committee on Human Research Protections (SACHRP), has presented its concerns and recommendations for alterations in the privacy rule that protect individuals from the real risks associated with intrusions of privacy, while continuing to enable the essential work of the biomedical and health sciences research community to flourish.

AAMC Policy/Recommendations

On September 1, 2004, the SACHRP submitted to HHS Secretary Tommy Thompson nine recommendations concerning needed clarification and modification of the final privacy rule, issued in August 2002 by the department under HIPAA, with respect to the privacy rule's impact on human subject research. The AAMC believes that SACHRP's recommendations must be acted on by HHS as soon as possible in the next administration.

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¹45 CFR Sec. 164.501

Responsible Use of Animals in Research and Education

Issue

Live animals continue to play an essential and irreplaceable role in research that is advancing biological knowledge, human health, and animal welfare. Animals also continue to play an important role in segments of the medical education continuum (undergraduate, graduate, and continuing medical education). Some members of the animal rights community have increased their efforts to harass and intimidate individual faculty members who use animals in research. Recent attacks on the homes of individual researchers at UCLA, UC–Santa Cruz, and other institutions are under investigation by both the FBI and local law enforcement authorities.

Background

Animal research has played a key role in virtually every major medical advance of the last century—to the benefit of both human and animal health. The Foundation for Biomedical Research and the National Institutes of Health (NIH) note that advances from antibiotics to blood transfusions, from dialysis to organ transplantation, from vaccinations to chemotherapy, bypass surgery and joint replacement, and practically every present day protocol for the prevention, treatment, cure, and control of disease, pain, and suffering are based on knowledge attained through animal research. Animal models continue to provide invaluable and irreplaceable insights into human systems. The essential need for animal research is recognized and supported by the Association of American Medical Colleges (AAMC), NIH, and medical societies and health agencies around the world.

Few data are available on the number of animals used throughout the medical education continuum. Some surveys show a downward trend in the use of animal laboratories in undergraduate medical education. Some of the reasons cited for this trend include competition for curriculum time has reduced lab availability; cost of lab time, supplies, space, and personnel; short supply of supervisory veterinarians; improvements in computer models; and the effectiveness of advocacy campaigns of animal rights activists that often target medical school deans, influential faculty, trustees, alumni, donors, and local media. Notwithstanding, some medical schools continue to assert that the use of animals is essential to their undergraduate medical education programs, and there is little doubt that

animals continue to be widely used in both graduate and continuing medical education, and are considered essential in certain specialties.

Recently, some members of the animal rights community have increased their efforts to harass and intimidate individual scientists who use animals in research. Recent violent attacks, including firebombings, on the homes of individual researchers at UCLA, UC–Santa Cruz, and other institutions, are under investigation by both the FBI and local law enforcement authorities.

Almost all medical schools and teaching hospitals whose faculties use animals in research and education participate in the voluntary accreditation and assessment program of the Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC). Institutions that earn AAALAC accreditation demonstrate their commitment to responsible animal care and use.

AAMC Policy/Recommendations

The AAMC strongly affirms the essential and irreplaceable role of research involving live animals in advancing biological knowledge, human health, and animal welfare. In addition, as animals continue to be vital in segments of the medical education continuum (undergraduate, graduate, and continuing medical education), the AAMC supports this use of animals to meet essential educational objectives.

The AAMC affirms the academic medical community's responsibility to ensure that the use of animals in laboratory research and medical education is judicious, responsible, and humane, and that the care provided to these animals fully meets accreditation standards and regulatory and legislative requirements. It is the association's firm belief that further restrictions on the use of animals in biomedical and behavioral research and education threatens progress in health care and disease prevention.



Policy Priorities to Improve the Nation's Health

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[http://grants.nih.gov/grants/policy/air/
researchers_institutions.htm](http://grants.nih.gov/grants/policy/air/researchers_institutions.htm)

Other Priority Health and Research Agencies

Issue

Medical discovery and advancement requires effective research across a continuum from basic science to clinical, health services, and health system research. Accordingly, it is vital to support research, health agencies, and initiatives across the federal government.

Background

Several federal agencies, both within and outside of the Department of Health and Human Services (HHS), award grants to medical schools and teaching hospitals to advance the continuum of research and discovery. These include:

Agency for Healthcare Research and Quality (AHRQ)—As the lead federal agency to improve health care quality, AHRQ's mission is to support research and disseminate information that improves the delivery of health care by identifying evidence-based medical practices and procedures. In support of this mission, AHRQ's budget includes a number of research initiatives designed to enhance consumer and clinical decision making, provide improved health care services, and promote efficiency in the organization of public and private systems of health care delivery.

To build an evidence base for clinical practice and improve health care delivery, AHRQ funds 14 Evidence-based Practice Centers located at Association of American Medical College (AAMC)-member institutions and other organizations to review relevant literature about selected topics and publish reports summarizing this information. In an effort to improve medical outcomes, AHRQ supports studies to evaluate the effectiveness of treatment strategies for many of the country's most prevalent and costly diseases. AHRQ's Centers for Education and Research in Therapeutics (CERTs) at medical schools, teaching hospitals, and other institutions, support research and education on the benefits and risks of new, existing, or combined uses of therapeutics.

AHRQ also is the leader on reducing health care costs, strengthening the translation of research into practice, and increasing access to medical technology. Additionally, to foster its important research, AHRQ provides an array of intramural and extramural predoctoral and postdoctoral educational and career development grants and opportunities in health services research.

Centers for Disease Control and Prevention (CDC)—As the nation's lead prevention agency, the CDC is responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. The CDC works with states, local public health agencies, and partners across the nation to monitor health, detect and investigate disease outbreaks, conduct research to enhance prevention, develop and implement sound health policies, foster healthy environments, and provide needed leadership and training in public health. The CDC is an important part of the public health continuum, and the AAMC's member institutions play a significant role in carrying out CDC's extramural programs, activities, and research.

Since October 2000, the AAMC has maintained a cooperative agreement with the CDC to emphasize the importance of improved and increased collaborations between public health and medicine. Collaborative activities include enhancing AAMC members' understanding of the CDC and its priorities and developing and carrying out AAMC-based "in-house" projects and traineeships. The cooperative agreement results in significant funded research conducted by the AAMC and its members. In fiscal year (FY) 2009, such research will total approximately \$8 million.

Health Resources and Services Administration (HRSA)—HRSA serves as the primary federal agency dedicated to improving access to health care services, especially for the uninsured, the underserved, and medically vulnerable populations. Tasked with strengthening the nation's health care safety net, HRSA grants augment other federal programs by supporting direct health care access for the uninsured, individuals with HIV/AIDS, and pregnant women, mothers, and children; the training of health professionals; and improved systems of care in rural communities. In addition to the Title VII health professions training programs and the National Health Service Corps (NHSC), HRSA also administers the Children's Hospitals Graduate Medical Education payment program, which provides funds to support the training of residents in children's hospitals.

With few exceptions, in recent years, HRSA has been plagued with drastically reduced funding, staff attrition, and frequent administrative reorganization, most notably within the Bureau of Health Professions (BHP). Further, HRSA's stated budget policy of prioritizing programs providing direct health care services marks a shift from HRSA's longstanding additional charge of improving health resources.

Policy Priorities to Improve the Nation's Health



National Science Foundation (NSF)—The NSF is an independent federal agency supporting basic science and engineering across all disciplines and is the second largest sponsor of research at colleges and universities after the National Institutes of Health. The NSF funds approximately 10,000 research, education, and training projects through grants, contracts, and cooperative agreements at more than 2,000 colleges, universities, and other research and education institutions. The NSF also plays an important role in supporting efforts to improve science, math, and engineering education at the K-12 level, as well as at colleges and universities.

As a member of the Coalition for National Science Funding (CNSF), the AAMC works with an alliance of more than 100 organizations united by a concern for the future vitality of the national science, mathematics, and engineering enterprise. CNSF supports the goal of increasing the national investment in the NSF's research and education programs in response to the unprecedented scientific, technological, and economic opportunities facing the United States.

AAMC Policy/Recommendations

In FY 2008, AHRQ was funded at \$334.6 million. As a member of the Friends of AHRQ, the AAMC recommended \$360 million for the agency in FY 2009. The AAMC supports funding the majority of AHRQ's budget through a direct appropriation.

In FY 2008, the CDC budget was \$6.4 billion. Given the challenges of terrorism and disaster preparedness, new and reemerging infectious diseases, and the nation's many unmet public health needs and missed prevention opportunities, the AAMC supports the recommendation of the CDC Coalition for a funding level of at least \$7.4 billion in FY 2009 to sustain a network of successful programs in illness and injury prevention and health promotion and to move cutting-edge health programs from idea to implementation.

The AAMC urges the new administration to prioritize a reinvestment in the nation's health resources programs through sustained, increased funding recommendations for HRSA. In FY 2008, HRSA received \$7.0 billion. As a member of the Friends of HRSA coalition, the AAMC recommends \$7.9 billion for HRSA in FY 2009.

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www.ahrq.gov
www.aamc.org/advocacy/laborhhs/ahrq/
www.cdc.gov
www.cdc-cafunding.org/
www.aamc.org/members/cdc/
www.hrsa.gov
www.nsf.gov
www.aamc.org/advocacy/research/nsf/
www.cnsfweb.org

Medicare and Teaching Hospitals

Issue

Medicare must continue its dedicated, stable, time-tested funding for the training of future physicians and the other valued contributions of teaching hospitals.

Background

The distinctive capabilities and responsibilities of teaching hospitals do not come without a price. Teaching hospitals incur significant costs associated with training new physicians and other health care professionals. They also have costs associated with using newly developed devices and technologies, maintaining standby services, treating patients with complex conditions, providing unfunded and underfunded health services, being sites for clinical research, and serving as safety net providers. These activities impose substantial financial burdens on teaching hospitals as demonstrated by their razor-thin total and operating margins; margins lower than those of other hospital groups.

Since its inception, the Medicare program has helped to fund the higher costs of teaching hospitals. Currently, two distinct payments are made to teaching hospitals. The Medicare direct graduate medical education (DGME) payment compensates teaching hospitals for Medicare's share of the costs directly related to the graduate training of physicians ("residency training"). These costs include the stipends and fringe benefits of residents, salaries and fringe benefits of faculty who supervise the residents, and other direct costs, such as costs associated with the GME office. Medicare only pays its "share" of these costs, based on a teaching hospital's ratio of Medicare inpatient days to total days. DGME payments are estimated to be about \$2.7 billion in fiscal year (FY) 2008.

Medicare indirect medical education (IME) payments are patient care payments with an "education" label. As the name suggests, IME payments help to cover Medicare's share of the higher "indirect" costs associated with patient care in teaching hospitals. Patient care costs at teaching hospitals are significantly higher than at their non-teaching counterparts; some analyses indicate these costs are more than 30 percent higher. The higher costs are due to a number of factors. There are costs associated with the inherent "inefficiencies" in service delivery-associated teaching and learning. Further, there are costs associated with the likelihood that patients seeking care in an academic medical facility will have illnesses that are rare or of greater severity than typical cases, and that more sophisticated medical

equipment is available in these institutions. The IME payment formula is based, in part, on each teaching hospital's intern/resident-to-bed (IRB) ratio and a nationwide adjustment factor. IME payments are estimated to be about \$5.7 billion in FY 2008.

In 1997, as part of the Balanced Budget Act, a hospital-specific limit was placed on the number of residents that a teaching hospital can count for purposes of receiving DGME and IME payments. However, because of their educational mission and the growing physician shortage, about half of teaching hospitals are training residents in excess of their caps, with no additional IME or DGME payments.

The AAMC represents nearly 300 nonfederal major teaching hospitals that are sites for the clinical training of nearly three-quarters of all medical residents. Consequently, the association closely monitors DGME and IME payment policy because of the important financial implications for its teaching hospital members, as well as the medical schools and faculty physician practices integral to their missions.

AAMC Policy Recommendations

To sustain the nation's teaching hospitals and the irreplaceable services they provide, the AAMC urges the following steps be taken:

- **Lift the Medicare Resident Caps**—The Medicare resident caps have been in place for more than 10 years while the nation is facing a physician shortage. The caps have a chilling effect on the ability of teaching hospitals and medical schools to increase the nation's physician workforce and meet the needs of local communities.
- **Maintain DGME and IME Payment Levels**—Given these times of increasing financial uncertainty for teaching hospitals, it is important that the Medicare program maintain its commitment made in 1965 to support the additional costs associated with the educational, research, and patient care missions of teaching hospitals.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Medicaid and Teaching Hospitals
- Emergency Preparedness

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www.aamc.org/advocacy/library/gme/gme0002.htm

Medicaid and Teaching Hospitals

Issue

Medicaid must continue its long-standing commitment to fund the training of future physicians, particularly as the nation faces a physician shortage.

Background

Since its inception, the Medicaid program has recognized its responsibility to fund its share of graduate medical education (GME) costs. In this context, the federal government has consistently approved and matched state Medicaid payments for both direct GME (DGME) and indirect GME (IME) (for an explanation of DGME and IME, see Medicare and Teaching Hospitals, page 33). According to a 2005 AAMC survey of state Medicaid programs, 47 states and the District of Columbia provided payments for DGME and/or IME costs, totaling \$3.2 billion in federal and state support for teaching hospitals and their missions.

Major teaching hospitals and physician faculty practices serve a disproportionately large volume of Medicaid beneficiaries. While representing just 6 percent of all hospitals, AAMC-member nonfederal teaching hospitals train three-quarters of all residents and account for 22 percent of all discharges. They also treat 28 percent of all Medicaid discharges and provide 41 percent of total hospital charity costs. Teaching hospitals care for vulnerable populations while simultaneously maintaining core missions of medical education, biomedical research, and innovative patient care. Any cuts to Medicaid directly threaten teaching hospitals' ability to maintain unique healthcare services that benefit all patients—not just Medicaid beneficiaries. Moreover, removing access for Medicaid patients will force them into already crowded emergency rooms, decreasing timely access to care for all patients.

With the issuance of a May 23, 2007, proposed rule, the Bush administration attempted—abruptly and without justification—to reverse long-standing Medicaid policy regarding GME costs. Specifically, the proposed GME rule “clarified” that GME costs are not expenditures for medical assistance and therefore not eligible for federal matching payments. According to estimates from the Centers for Medicare and Medicaid Services (CMS), the “clarification” would eliminate at least \$1.7 billion in federal Medicaid funds. The current prohibition on any regulatory action regarding the proposed rule expires April 1, 2009. The Association of American Medical Colleges (AAMC)-supported moratorium was enacted as part of the

“Supplemental Appropriations Act, 2008” [PL 110-252] prohibiting implementation of the regulation.

AAMC Policy/Recommendations

GME support has never been more important, given the nation's physician shortage and the aging of the nation's population. Any cuts to Medicaid will also directly threaten unique health care services—including emergency response capacity and trauma systems—that benefit all patients.

Future policy must maintain Medicaid's 40-year support of teaching hospital missions, and the next administration should not issue or finalize regulations that abrogate this commitment.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Medicare and Teaching Hospitals
- Teaching Hospitals as Safety Net Providers
- Emergency Preparedness
- Physician Workforce Issues

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www.aamc.org/advocacy/teachhosp/medicaid/



Teaching Hospitals as Safety Net Providers

Issue

Public and private payers must continue to recognize and help fund the additional costs incurred by safety net providers.

Background

The term “safety net provider” is used to identify those health care entities providing a disproportionate amount of health care to uninsured and underinsured patients. With the number of uninsured Americans totaling 46 million and underinsured Americans comprising another 25 million, the burden on these providers is greater than ever.

Many major teaching hospitals, medical schools, and their clinical physician faculties historically have served as fundamental components of the nation's health care safety net. While representing just 6 percent of the nation's hospitals and 22 percent of all discharges, AAMC-member nonfederal teaching hospitals provide 41 percent of total hospital charity care in this country. Also, because they have large ambulatory clinics, the nation's teaching hospitals (often in collaboration with medical school clinical faculty) provide large amounts of ambulatory care for indigent patients, frequently acting as a medical home for neighborhoods lacking access to community-based practices.

States and the federal government provide some financial support to help offset the additional costs associated with treating Medicaid and uninsured patients through a variety of ways. Medicare and Medicaid “disproportionate share (DSH) payments are the two most important and critical resources. Medicare DSH payments total about \$9.4 billion annually, and Medicaid DSH payments total approximately \$10.4 billion.

AAMC Policy/Recommendations

Teaching hospitals rely on payments they receive from various state and federal sources to help offset the costs they incur by serving as safety net providers.

While the Association of American Medical Colleges (AAMC) and its members support and endorse health care reform that would provide insurance coverage to all, it would be premature and illogical to consider reducing or redirecting Medicare and Medicaid DSH payments before any expansion of health care coverage has occurred. As coverage expansion occurs, it also will be important to remember that there still will be individuals who, for a variety of reasons, will not have insurance coverage but still will be treated by health care providers. In addition, because provider payments vary by payor, and Medicaid payments are often among the lowest, hospitals that continue to treat a disproportionate number of Medicaid patients will need additional ongoing financial support to fill the gap between actual costs and insufficient levels of reimbursement.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Medicare and Teaching Hospitals
- Medicaid and Teaching Hospitals

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Medicare Physician Payments

Issue

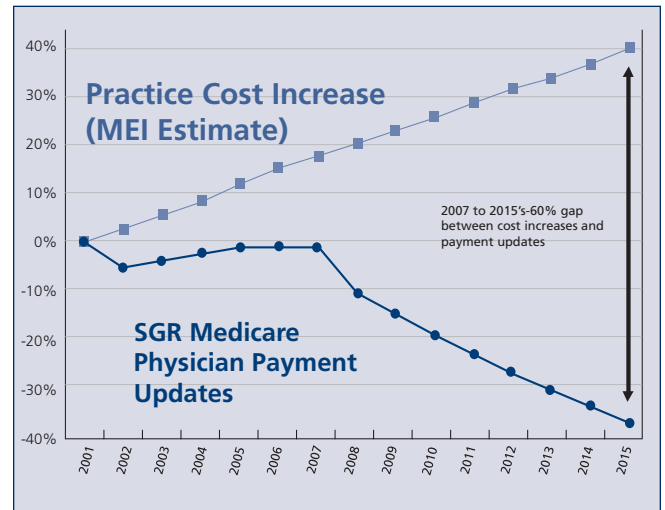
Adequate reimbursement for physician services is vital to sustain the mission of academic clinical physicians. On average, Medicare accounts for one-quarter of teaching physician revenue and, in turn, faculty practice plan revenues account for more than one-third of total medical school revenues. The current statutory formula for updating Medicare physician payments will produce negative updates for the next several years, affecting payments from Medicare and also from private payers since they frequently follow Medicare payment policies.

Background

In 1992, Medicare began paying for physician services through a fee schedule that priced individual services using a set of relative weights (called relative value units or RVUs) for physician work, practice expense, and professional liability. These weights are adjusted for geographic differences and then multiplied by a conversion factor to convert the adjusted RVUs to a dollar amount. However, the fee schedule did not provide incentives for physicians to control volume or intensity of services.

In an effort to address the growing volume and cost of services, Congress passed the Balanced Budget Act of 1997, which mandated that a Sustainable Growth Rate (SGR) formula be used to determine the annual change in the conversion factor. The SGR compares aggregate Part B spending to a national target based on inflation, the number of fee-for-service Medicare beneficiaries, the Gross Domestic Product (GDP), and changes in laws and regulations that affect physician service utilization or spending. Initially, total physician spending was below target, so physician fees increased annually. In 2002, spending for physician services exceeded the spending target, resulting in a negative update. The spending target also has been exceeded in all subsequent years. Thus far, Congress has intervened to prevent these subsequent reductions from going into effect. However, the SGR is a cumulative target, so every year that Congress intervenes but does not change the SGR formula, the cumulative deficit (and cost of funding future changes) grows.

Below is a chart prepared by the American Medical Association (AMA) (using 2007 data) comparing the costs of medical practice (using the Medicare Economic Index or MEI) with the projected updates to the conversion factor.



Source: AMA

In its report to Congress in March 2007, the Medicare Payment Advisory Commission (MedPAC) acknowledged the SGR's flaws without clear recommendations on how it should be replaced or modified. One reason the SGR has not been changed is the high cost of replacing it with another payment system. In March 2008, the Congressional Budget Office (CBO) estimated the five-year cost of a zero percent update (maintaining current fee schedules) for 2009 was \$35 billion. In 2010, absent congressional action, the CBO estimates a cut of 20.1 percent to physician payments under the SGR formula.

Teaching physicians care for the sickest, most complex Medicare patients and provide primary care as well as highly specialized services that may not be available elsewhere in the community. Moreover, academic physicians often serve as a resource for other health care providers in communities and across regions, providing consultations and care for Medicare patients who need their specialized expertise, while at the same time teaching the next generation of physicians. Without reliable, sufficient, and fair physician payment adjustments from Medicare, many of these services may be placed in financial jeopardy adversely affecting Medicare beneficiaries' access to vital care.



Policy Priorities to Improve the Nation's Health

AAMC Policy/Recommendations

The AAMC supports replacing the SGR formula with a payment system that, at a minimum, adequately compensates physicians based on such factors as the services provided, complexity of the patients served, and geographic area where the physician practices, while also accounting for increased costs due to inflation.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues

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Medical Home

Issue

Many Americans feel “medically homeless” in a health care system that is difficult for patients to navigate when they need care or advice. Patients and providers alike are deeply dissatisfied with the current delivery system. New models of care delivery must be developed, focusing on patients and their problems while improving delivery and outcomes.

The medical home, while not a cure-all for the current fragmentation, offers a powerful potential model likely to improve patient care satisfaction and outcomes.

Background

The medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for the patient/family’s cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services. Its functions are similar to those of effective primary care proposed several decades ago by the Institute of Medicine (IOM), the World Health Organization (WHO), and others. In fact, the term was originally coined in 1967 by the American Academy of Pediatrics (AAP), but the concept in its current form was formulated by the academy in a 1992 position paper as an “approach to providing comprehensive primary care.”

Much evidence supporting the medical home model is extrapolated from the literature evaluating primary care, case management, and other approaches to improving care coordination and prevention. The limited evidence available from studies more closely examining the role of the medical home is encouraging. Further studies are needed to better define the core functions of the medical home, its optimal implementation, and how strategies might need to be adjusted for populations with different degrees of acute and chronic illness. Perhaps the greatest challenge will be the additional resources required to adopt medical homes before cost savings (if any) are realized.

The Association of American Medical Colleges (AAMC) has recently called for an expansion of medical education and training in the U.S. to ensure that physicians are available to care for a growing population of aging and chronically ill citizens. However, the association and its members believe that physicians and other health care providers are only the first step to improving the health of communities, and that patients must be able to access effective care for both prevention and treatment.

Despite the need for better information about optimal form and function, and the attendant challenges to implementation, the AAMC believes that the medical home model holds great promise for improving the health of populations and individuals.

In March 2008, the AAMC adopted a position statement endorsing the medical home model and committed to working with its member institutions to better understand how the medical home model can be adopted in academic and community settings. Moreover, the association and its members look to these new models of care to train and educate physicians in a delivery system that improves patient satisfaction and outcomes while improving the value of health care.

AAMC Policy/Recommendations

Every person should have access to a medical home—a person who serves as a trusted advisor and provider supported by a coordinated team—with whom they have a continuous relationship.

The federal government must invest in the further research necessary to better understand how to measure the core functions of the medical home and to develop an evidence base for how the model is best implemented.

Payment for the medical home model should appropriately recognize and reward health care providers for their contributions to prevention, patient care, and care coordination.



Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Primary Care

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Web Resources

www.aamc.org/medicalhome
www.urban.org/events/other/Medical-Homes.cfm
www.aamc.org/newsroom/reporter/may08/resident.htm

Health Care Quality

Issue

Improving the quality of patient care and advancing clinical improvements are an integral part of Association of American Medical Colleges (AAMC) members' missions of patient care, research, and medical education. Teaching hospitals and teaching physicians are at the cutting edge of quality improvement while serving the most complex and chronically ill patients in the nation.

Background

The AAMC takes a leadership role in several national organizations and initiatives at the forefront of the nation's health care quality agenda. These alliances include:

Hospital Quality Alliance (HQA)—The AAMC is a founding member and principal of the Hospital Quality Alliance (HQA). The HQA is a public-private collaboration comprising hospital associations, other provider organizations, accrediting agencies, government, consumers, and businesses. It is committed to improving the quality of hospital care through voluntary quality measurement and public reporting. The goal of the HQA is to collect and disseminate data on a robust set of standardized and easy-to-understand hospital quality measures.

As a member of the HQA, the AAMC promotes the use of quality information to improve patient care among member institutions. Additionally, because the AAMC represents teaching hospitals, teaching physicians, and other health professionals, its staff offer a unique perspective during the HQA decision-making process that recognizes the special characteristics of providing hospital care in an academic setting. The AAMC chairs the measure workgroup, which is responsible for recommending to the HQA principals which measures should appear on the Hospital Compare Web site.

Ambulatory Quality Alliance (AQA)—The Ambulatory Quality Alliance (AQA) is a broad-based collaboration of physicians, consumers, purchasers, health plans, and others. Its mission is to create a strategy for measuring physician performance, aggregating and sharing the data within the physician community, and ultimately sharing the information with the public. AAMC members and staff serve on various AQA workgroups, providing input on quality measurement issues unique to physicians who practice in an academic setting.

National Quality Forum (NQF)—The AAMC is a founding member of the National Quality Forum (NQF) and has a voting seat on the Provider Organizations Council. A private, nonprofit membership organization, the NQF developed, implemented, and now maintains a national strategy for health care quality measurement and reporting. Its primary role is to endorse quality measures through a consensus development process. The Hospital Compare and the CMS Physician Quality Reporting Initiative (PQRI) use subsets of the measures endorsed by the NQF.

Quality Alliance Steering Committee (QASC)—The Quality Alliance Steering Committee (QASC) was commissioned by HHS Secretary Mike Leavitt to better coordinate the promotion of quality measurement, transparency, and improvement in care across provider groups and the broader health care community. The AAMC is a principal member of the QASC.

AAMC Policy/Recommendations

The federal government should continue to encourage policies that help providers advance quality and patient safety. New policies and quality measures must be developed in conjunction with national provider stakeholder groups and consortia.

The AAMC, in conjunction with other hospital associations and representative organizations, has worked together to develop a unified set of principles for implementing a system to reward hospital performance. The association believes these principles are essential in developing a payment-based system:

- Hospital, physician, and other providers' incentives should be aligned.
- Incentive approaches should be developed collaboratively, involving all stakeholders.
- Incentive approaches should provide rewards that will motivate change.
- Incentive approaches should be implemented incrementally.
- Quality improvement and quality attainment both should be rewarded.
- The measures used to assess performance should be developed in an open, consensus-based process and selected to streamline performance measurement and reporting.



Policy Priorities to Improve the Nation's Health

- The measures used to assess performance in a pay-for-performance system should be evidence-based, tested, feasible, and statistically valid.
- The measures should accurately recognize differences among hospitals and the patients they serve.
- Efforts should be taken to ensure that the measures used do not institutionalize existing care disparities.

Beyond the unified hospital principles, the AAMC believes that the unique patient population and clinical care environments of academic medicine should be considered in developing any new quality efforts at the national level. Quality measures must recognize the complexities of the teaching hospital patient population who often suffer from multiple co-morbidities and complications. An appropriate risk adjustment methodology should be utilized to account for those differences in patient populations. The AAMC supports finding ways to measure the value of care our teaching hospitals and clinical faculty provide as part of academic medicine's overall commitment to providing high-quality care for patients.

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Web Resources

www.aamc.org/quality
www.hospitalcompare.hhs.gov
www.hospitalqualityalliance.org

Health and Health Care Disparities

Issue

A more culturally and ethnically diverse society requires a more diverse and culturally competent health care workforce to address health disparities among racial, ethnic, and economic groups. The nation's teaching hospitals and physicians provide frontline care for the medically underserved—especially those who are uninsured or underinsured. Supporting the efforts of medical schools and teaching hospitals to mitigate health and health care disparities is fundamental to achieving better health for all.

Background

Considerable research demonstrates differences in access to, and quality of, medical care for members of racial and ethnic minority groups in the United States. For example, 51 percent of Hispanics/Latinos report having no regular doctor, compared with 21 percent of whites.¹ Black men are 50 percent more likely to develop prostate cancer than white men, and are twice as likely to die from it.² The impact of these differences often is compounded by entrenched social and economic inequities.

Efforts to address health and health care disparities have coalesced around evidence that increasing diversity in the health professions workforce and improving cultural competence training for physicians will result in an increased quality of care for all. Studies repeatedly show that African American, Hispanic/Latino, and Native American physicians are more likely to practice in underserved communities and to care for a disproportionate number of disadvantaged patients. Additionally, a diverse physician workforce contributes to greater health care access for the underserved as studies have documented increased patient satisfaction in encounters with physicians from similar racial and ethnic backgrounds. Cultural competence training across the medical education curriculum equips all physicians to provide optimal health care to patients from diverse backgrounds.

Though the Association of American Medical Colleges (AAMC) nonfederal teaching hospital members represent 6 percent of all hospitals and 22 percent of hospital discharges, they provide 41 percent of all charity care nationwide. AAMC partnerships in national health-improvement and quality initiatives, such as Healthy People 2010 and the Hospital Quality Alliance, provide frameworks for connecting the health care AAMC constituents provide to efforts to eliminate disparities. Expanding medical research collaborations with community-based providers and practice-based research networks can begin to increase diversity among participants in clinical and translational research and enrich the nation's biomedical research agenda.

AAMC Policy/Recommendations

The federal government should renew its commitment to Title VII and other efforts to diversify the health care workforce and improve health status.

The AAMC's strategic responses to address health and health care disparities include:

- Unwavering commitment to expanding diversity in the physician workforce through outreach, pipeline programs, and holistic review in the admissions process;
- Supporting cultural competence training—including teaching about racial and ethnic disparities in health and health care—across the medical education curriculum; and
- Promoting constituents' collaborations with community health care providers and practice-based research networks to broaden diversity and access to clinical and translational research.

¹ The Commonwealth Fund. Health Care Quality Survey. 2006

² National Center for Health Statistics. Health, United States, 2006: With Chartbook on Trends in the Health of Americans. 2006.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues
- Health Professions Education Legislation (Title VII)
- Teaching Hospitals as Safety Net Providers
- Health Care Quality
- Research Training

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Web Resources

Aspiring Docs.org, the AAMC's career marketing effort to increase diversity in medicine: www.Aspiringdocs.org

Facts & Figures data series on minorities in medicine
www.aamc.org/factsandfigures

Holistic Review, Roadmap to Diversity
www.aamc.org/roadmaptodiversity

Promoting Translational and Clinical Science: The Critical Role of Medical Schools and Teaching Hospitals:
https://services.aamc.org/Publications/index.cfm?fuseaction=Product.displayForm&prd_id=150&prv_id=176

Summer Medical and Dental Education Program (SMDEP): www.smdep.org

Tool for Assessing Cultural Competence Training (TACCT): www.aamc.org/meded/tacct/

Hospital Not-For-Profit Status

Issue

It is essential for federal, state, and local governments to recognize and give credit to not-for-profit hospitals and health systems for the wide range of community benefits they provide. These benefits include charity care, teaching, research, and related community service activities.

Background

The federal Internal Revenue Service (IRS) has never articulated a standard for hospitals to be tax-exempt beyond the “5 pillars” found in Revenue Ruling 96-545:

- A board composed of citizens in the community
- Medical staff privileges open to all qualified physicians, consistent with the size and nature of the facility
- Organized and operated exclusively in furtherance of a charitable purpose
- Full-time emergency room; no one requiring emergency care is denied treatment
- Excess funds applied to facilities and equipment, and improvement in patient care, medical training, education, and research

Beginning with the 2009 tax year, a newly adopted Schedule H must be completed by hospitals that file a Form 990. This is the IRS’s first attempt to gather consistent information about “community benefit.” At this time it does not impose a requirement for any specific type or amount of community benefit to be provided to (achieve) tax-exempt status, though the information it collects may be used to bolster such efforts.

AAMC Policy/Recommendations

- Experience from the Catholic Health Association efforts on reporting community benefit suggest that it takes several years for hospitals to become proficient at collecting and reporting this information. Therefore, the government should take no action to impose community benefit requirements on tax-exempt hospitals until it has collected several years of data from Schedule H.

- Any requirements related to community benefit should recognize the many activities that benefit the communities in which hospitals function, including, but not limited to, charity care, unreimbursed costs from Medicaid and other payers, subsidized health services, teaching, research, and community building.
- When considering the amount of community benefit provided, the IRS allows reporting only by employer identification number (EIN). This means that if a health system has multiple hospitals, and each has its own EIN, the reporting is done on a hospital-by-hospital basis rather than system-wide. This is likely to disadvantage health systems that plan their community benefit activities on a coherent system-wide basis. Therefore, the IRS should allow health systems to report community benefit on a system-wide basis.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Teaching Hospitals as Safety Net Providers
- Medicaid and Teaching Hospitals
- Emergency Preparedness

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Malpractice/Medical Liability Reform

Issue

AAMC-member institutions find themselves increasingly burdened by rising medical malpractice premiums. To cover the rising premium costs, many teaching hospitals and faculty physicians are forced to focus increasing time and resources on medical liability concerns rather than their core missions of providing quality patient care, research, and education.

Background

The Government Accountability Office and others have identified rising malpractice claims as a driver of increased liability premiums. Along with driving up the costs of premiums—which increase the overall costs of health care in the nation—fear of unfounded litigation makes the practice of “defensive medicine” more likely. Physicians and other providers must perform tests and procedures they know are marginally beneficial in order to decrease their risk of malpractice claims, raising the costs of care for all patients and payers. Liability costs are particularly difficult for physician practice plans whose faculty may devote only part of their time to clinical practice (in addition to research and educational activities) yet must pay malpractice premiums equal to those practicing full time. These increased costs also contribute to why physicians are more likely to retire early from the workforce at a time when the nation is facing a physician shortage.

As a member of the Health Coalition on Liability and Access (HCLA), the AAMC supports enactment of comprehensive medical liability reform legislation (described below). Other HCLA members include the American Medical Association, American Hospital Association, physician specialty societies, and malpractice insurers.

AAMC Policy/Recommendations

As a member of HCLA, the AAMC supports comprehensive medical liability reform legislation that includes:

- Unrestricted awards for economic damages
- A \$250,000 cap on non-economic damages (“pain and suffering”)
- Capping punitive damages at the greater of \$250,000 or twice economic damages
- Limits on attorneys’ contingency fees
- “Joint and several liability” reforms
- No double recovery of damages
- Payment of certain awards over time.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Physician Workforce Issues

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Emergency Preparedness

Issue

The U.S. health care system's ability to respond to natural and human-induced disasters depends heavily on teaching hospitals, their facilities, and their staff. Maintaining emergency preparedness within communities will require ongoing, stable support for the surge capacity and special capabilities of teaching hospitals.

Background

The nearly 400 major teaching hospitals and health systems represented by the Association of American Medical Colleges (AAMC) are complex institutions with more surge capacity and specialized treatment capabilities than average acute care hospitals. As a result, these institutions have served as important contributors during natural disasters (such as Hurricanes Katrina and Rita) and infectious disease outbreaks. Mass casualties often require Level 1 trauma centers, most likely to be found in major teaching hospitals. The ability to respond to these catastrophic events, though, is limited severely by overall available resources and the ability to achieve surge capacity.

Maintaining specialized treatment facilities—including trauma centers, decontamination units, advanced life support care, burn units, and other services and facilities—are part of the core patient care mission of major teaching hospitals. These facilities and the personnel required to staff them are partly responsible for the higher costs of patient care at major teaching hospitals. These costs are offset to some degree by the special payments made by Medicare and Medicaid as part of their commitment to supporting these institutions.

AAMC members, including teaching hospitals, medical schools, and their faculties, also play a major role in ensuring that the health professions workforce is prepared to respond to these events within their communities. Faculty physicians, teaching hospital staff, and physicians-in-training are front-line responders during community crises. In 2005, the Centers for Disease Control and Prevention (CDC) found that teaching hospital staffs have the most training for terrorist attacks and mass casualties.

The AAMC, with support from the CDC, convened a multidisciplinary group of experts in 2002 to determine what medical students and physicians should learn about bioterrorism. The resulting report recommended that all health professionals be educated to recognize and treat the effects of bioterrorism, chemical terrorism, and radiological terrorism. Many of the subjects in a weapons of mass destruction (WMD) curriculum are already part of traditional medical school teaching. Instruction in pathophysiology, toxicology, infectious diseases, emergency preparedness/disaster response, biostatistics, and epidemiology introduce concepts and topics that are the foundation for information more specific to WMD preparedness and response. The medical education and training community continues to advance curriculum so that it evolves with the health preparedness needs of society.

AAMC Policy/Recommendations

Medicare and Medicaid must continue to provide stable support for the highly specialized clinical missions of teaching hospitals that include the ability to respond to mass casualties and disasters, both natural and human-induced.

Related Issues of Interest

Related issues or issues covered in greater detail in this binder include:

- Medicare and Teaching Hospitals
- Medicaid and Teaching Hospitals

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Web Resources

www.aamc.org/preparedness/
www.aamc.org/advocacy/laborhhs/bioterror/
www.aamc.org/newsroom/bioterrorism/bioterrorismrec.pdf



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