

**2009 National Health Policy Conference**  
 Sponsored by AcademyHealth and *Health Affairs*

**Breakout session:  
 Strengthening the Healthcare Workforce through  
 Policy and Planning**

Jack Ebeler  
 February 3, 2009  
 11:30 am – 1:00 pm

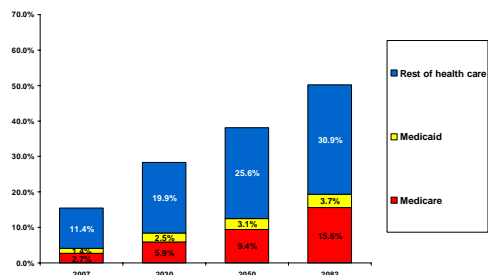
**Outline**

**Context: fiscal situation**

**Two different ways to look at Medicare policy re: workforce**

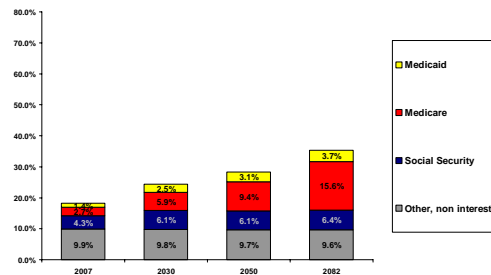
- Medicare as significant financier of graduate medical education
- Medicare as payor/shaper of delivery system in which health professionals will work in the future

**Context: fiscal situation: health care (both public and private) continues to grow as a share of GDP**



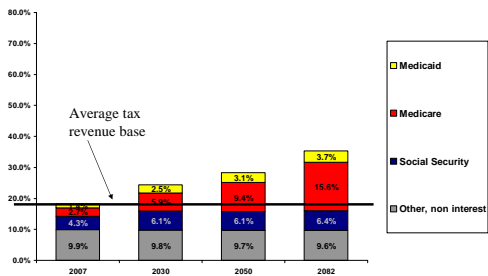
CBO Long Term Budget Outlook, 2008, Alternative Fiscal Scenario

**Context: the federal budget: Medicare and Medicaid account for higher shares of GDP and drive the federal budget up as well**



CBO Long Term Budget Outlook, 2008, Alternative Fiscal Scenario

**The federal budget: budget projections far exceed historical levels of taxation**



CBO Long Term Budget Outlook, 2008, Alternative Fiscal Scenario

**Medicare is substantial supporter of GME**

**In 2007, Medicare payments for GME totaled \$8.9 billion**

- \$2.9 billion in direct costs for graduate medical education
- \$6.0 billion for the indirect costs – the IME adjuster
  - About ½ is actual estimate of the costs of care associated with interns and residents
  - About ½ is extra payment on top

(MedPAC, October 2008 presentation)

**With pipeline for education, look out over ten years**

Medicare will provide about \$90 billion over the next 10 years

- About \$30 billion for direct costs
- About \$30 billion for the actual indirect costs
- About \$30 billion in addition of indirect costs

Issue is whether/how to shape that funding -- at appropriate levels -- to support the changes needed

**Medicare as payor/supporter/shaper of delivery system**

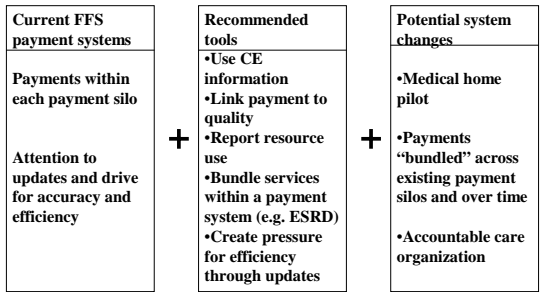
Problems well known, and driven by general problems with FFS medicine

- Care coordination is all too rare
- Specialty care favored over primary care
- Quality inadequate and highly variable
- Health care costs high, variable and unsustainable

Need for fundamental reform; improving delivery is focus of change; need to define payment approaches to support and incent the changes

(MedPAC June 2008 Report; September Testimony to Senate Finance Committee)

**MedPAC direction for payment and delivery reform**



(MedPAC June 2008 Report; September Testimony to Senate Finance Committee)

**Selected MD payment directions**

- Promoting primary care
  - Fee schedule adjustment for primary care
  - Medical home pilot:
    - Rigorous standards
    - Care coordination for those with multiple chronic condition
    - Monthly fee in addition to FFS payments
  - Change RUC process
- Measure and report resource use
- Payment accuracy for imaging

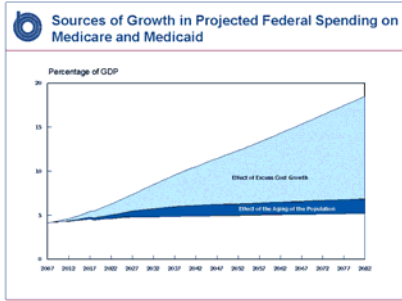
**Conclusion**

- Issue is how to shape health professions education:
  - Not to support past or current system
  - But to lead and participate in the health delivery system needed in the future
- Medicare payment policy can help shape that delivery system, and support and incent the changes in education
- Balancing act: need for clear direction and incentives – a vector of change - and need for ongoing adaptability within health professions education

THANK YOU

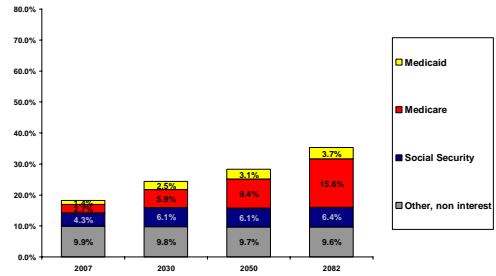
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**Growth in federal health spending: “excess cost growth”, not aging, is the issue**



CBO, November 2007

**The federal budget: Medicare and Medicaid account for higher shares of GDP and drive the federal budget up as well**



CBO Long Term Budget Outlook, 2008, Alternative Fiscal Scenario

**Variation: within US (Medicare); International (US V. OECD)**

We see variation both within the U.S., (Medicare) as well as among the U.S. and other nations.

One message is that, within the U.S. regions and states have likely achieved health spending levels well within the norms of the next highest nations.

Note: there would undoubtedly be substantial variation within other nations as well.

