Managed care and graduate medical education: Mutual objectives, barriers, and prospects

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Osteopathic medical schools are in an excellent position to cooperate with managed care providers because of an overlap of their common objectives. The authors maintain that osteopathic medical schools and managed care providers need to work together to promote integrated graduate medical education–managed care systems or face the possibility of being at the mercy of a fragmented healthcare reform movement. Issues related to common objectives and barriers to integrated graduate medical education–managed care systems are discussed, along with possible solutions.

(Key words: academic medical centers [AMCs], graduate medical education [GME], healthcare delivery, healthcare reform, health maintenance organizations [HMOs], managed care, managed care organizations)

Background
Nationally, healthcare reform has focused on economic incentives that have the potential to decrease costs. This approach, in turn, has led to the proposed adoption of managed care as the vehicle to deliver healthcare services. Although not clearly defined, managed healthcare refers to a variety of systems and programs administered by organizations or corporations designed to facilitate healthcare delivery to large patient populations, while optimizing cost efficiency.

Central to the emphasis on managed care is the notion of “accountable health plans.” Our literature review relies heavily on findings, experiences, and generalizations drawn from that of health maintenance organizations (HMOs). However, Mullan and colleagues point out that a spectrum of practice arrangements meets the accountable health plan criteria required for managed care. These criteria include preferred provider organizations, individual practice associations, multispecialty groups, and individual providers.

The roots of the current healthcare crisis can be traced, in part, to the failure of the primary care specialties (family practice, general internal medicine, general pediatrics) to attract physicians. Confounding the medical communities’ ability to deal with access and cost of care is the concomitant rise in specialization. For example, Mullan and associates note factors such as physician-mandated services and physician-induced demand as being critical to healthcare reform.

We do not oppose the emphasis on the generalist/specialist mix as a central ingredient in healthcare reform. In fact, this emphasis does endorse the need expressed by Mullan and coauthors to take a broader perspective. This perspective emphasizes market forces driven by large employers, health insurance purchasing cooperatives (HIPCs), previous clinical arrangements, and even geography as factors that will ultimately shape the pattern of service delivery organizations that will emerge as the universal health system.
Historical perspectives

More than 20 years ago, Lyon and associates\(^3\) outlined the problems and issues inherent in relationships between academic medical centers (AMCs) and HMOs. These researchers focused on "the ambiguities and uncertainties associated with developing federal guidelines and with changes which may occur as new health care is enacted,"\(^3\) and then used their experiences at Michigan State University as a means to provide some understanding of the problems inherent in the AMC-HMO relationship.

According to Thomas\(^4\) and Falk\(^5\), an AMC has two options if it is to have some formal relationship with an HMO. It could either directly sponsor or own an HMO, or it could affiliate itself with some program owned and operated by someone else. Regardless of the type of arrangement described, the early literature discussing HMO-graduate medical education (GME) linkages reflects primarily the concerns of academic medicine. These concerns include:

- the issues and problems in the AMCs' involvement with HMOs, such as the gap between the need for primary care physicians and a lack of access to and availability of primary care opportunities in allopathic medical school hospitals\(^6\);
- faculty and governance issues for AMCs involved with HMOs, specifically, firmly entrenched attitudes, standards, and behaviors of academic medical faculty and leaders that will require realignment in HMO settings; and the potential conflict between the university's role as a traditional academic institution and as a sponsor of an HMO\(^7,8\);
- issues related to teaching in HMO settings, such as teaching ambulatory care in HMO settings can overcome some of the difficulties encountered in traditional university teaching clinics.\(^9\)

The more recent medical literature addresses the problems inherent in the managed care system itself:

- HMO personnel and training needs\(^10\);
- the role of HMOs in GME\(^11\);
- the financing of GME in HMO settings\(^12\); and
- barriers to the integration of GME and managed care.\(^13\)

A number of forces are at work that will require the integration of GME into managed care systems. Some of these forces have historical roots, while others are more modern in origin. Yet, the scope of the current healthcare crisis extends beyond these factors, to include the provision of universal healthcare and the attempt to integrate delivery systems. This integration of GME will very likely take the form of managed care systems. Thus, the objectives, barriers, and solutions to an integrated managed care-GME system warrant a closer examination.

Working toward a symbiotic managed care-GME integration

Objectives

Mullan and associates\(^1\) maintain that workforce reform is central to healthcare reform. The first priority is to train generalist physicians and to continue to provide continuing medical education in the generalist disciplines of family practice, general internal medicine, and general pediatrics. Other concerns regarding workforce reform include:

- a physician workforce that reflects the population's racial/ethnic diversity;
- an equitable distribution of the physician supply to ensure full geographic access to healthcare to the public;
- the establishment of a target physician workforce to maintain the target ratio at current levels; and
- the establishment of supply needs for other healthcare providers, including nurse practitioners, physicians' assistants, and certified nurse midwives.

Mullan and coauthors\(^1\) also discuss several strategies for reform. Among these strategies are commissions, educational consortia, adequate funding, accreditation, and certification reform and income management.

Emphasizing that the current system of medical education is disjointed, Mullan and colleagues\(^1\) call for public funds earmarked for medical education. Specifically, these funds would be used to stimulate the formation of consortia of medical schools and teaching hospitals that would affiliate with HMOs, community health centers, and public health departments. Each consortium would be responsible as a unit for the ultimate specialty choices of trainees. Continual receipt of federal and state funds would be tied to policy goals, namely, producing more generalists.

It is unclear as to whose goals should predominate regarding the integration of managed care and GME. The new order proposed for managed care may reflect the interests of a number of entities. From our perspective, managed care providers and AMCs concerned with provision of GME need to work out their own mutual objectives.
Barriers

Before looking at barriers to future collaborations, the extent of existing relationships between managed care and GME programs deserves examination. Corrigan and Thompson surveyed 481 HMOs to assess their level of involvement in GME. Similarly, these researchers sampled residency programs to determine the extent to which residents and resident program faculty are participating in HMOs, and whether HMO enrollees are serving as the patient base for GME in ambulatory care settings.

They found that 15% of their sample of HMOs were directly involved in GME. Direct involvement meant that the HMO had been approved by the Accreditation Council for Graduate Medical Education to serve as a sponsoring organization of a GME program, or that the HMO had a formal agreement with an AMC or teaching hospital to serve as an ambulatory care rotation site, or that the HMO had both arrangements.

Of the residency program respondents, 42% indicated that they contract with HMOs to provide services to enrollees. The breakdown by specialty was as follows: family practice, 64%; internal medicine, 28%; and pediatrics, 24%. However, for the most part, these relationships have not been formulated for purposes of GME. Rather, they are contractual arrangements under which physicians or groups agree to provide services to HMO enrollees in return for compensation.

Moore directly assessed the barriers to collaboration between HMOs and AMCs. Approximately 450 academicians and HMO medical directors responded to a case Moore prepared designed to elicit barriers and identify incentives for cooperation between AMCs and HMOs. He found that AMCs and HMOs each harbor suspicions about the other that impede collaboration.

Specifically, HMO leaders thought what obstructed GME was a potential loss of managerial control, threats to productivity, and concern regarding patient acceptance. Leaders of HMOs thought that they must be free to manage staff, space, and service. They also thought that teaching costs more than the HMOs receive in services from the students and residents. The HMO physicians often stated that patients would be dissatisfied if students participated in their visits.

The AMCs also expressed barriers to collaboration, which included trivial medical problems; no money to pay for extra cost of teaching ambulatory care; and the possibility that the academic order might be subverted by extending participation to nonacademic physicians. Ambulatory care patients were seen as providing few important pathophysiology lessons. Furthermore, the time frame in managed care settings did not allow for students to follow up patients. The AMC leaders also perceived that it costs more to teach medical students and residents in ambulatory care settings than in hospitals. Teaching in any ambulatory care setting is seen as a situation that inherently generates financial losses. Finally, AMC leaders perceived clinical faculty who worked in managed care settings to be less scholarly than those within the academic setting.

Despite their concerns, each of these entities can reap clearly identified potential benefits by working together. Moore maintains that cooperation will ensue as medical educators will experience growing pressure to involve HMOs in teaching. The HMOs appear to be desirable as teaching facilities because of their access to patients outside hospital settings. Also, HMOs can make substantial contributions to faculty personnel. The corporate structure and large size of HMOs make them efficient partners for teaching ambulatory care.

The HMO medical directors face problems that an academic affiliation could ameliorate. With their projected growth rate, HMOs could absorb virtually all the present primary care graduates. The HMOs will recognize the special advantages that come with participating in teaching, including enhanced physician recruitment. Given that the vital concerns of both AMCs and HMOs do not directly conflict with each other, these parties should be able to negotiate.

Other areas—particularly money—pose more problems. Medical schools or hospitals (or both) must be prepared to help with financial reimbursement.

Solutions

The academic side of the AMC-managed care equation still has the same concerns it had more than 20 years ago. Having been on both sides of this fence, we have perspectives tempered by some experience with both GME and managed care.

The AMCs are not monolithic entities. The differences between allopathic and osteopathic medical schools are critical in the search for solutions to the GME–managed care integration issue. Clearly, osteopathic medical schools and managed care providers are more likely than allopathic medical schools to share objectives related to the production of primary care physicians. Despite
the concern over the physician mix, no indication has been made that osteopathic medical schools will cease to produce more than their representative share of primary care providers.

Actually, this endemic primary care tradition transfers to the need of the colleges of osteopathic medicine (COMs) to train students and residents in primary care settings. As such, many of the issues that allopathic AMCs perceive as barriers to collaboration are nonexistent or slight at best in osteopathic AMCs and COMs. The question remains, then, why are COMs and managed care providers not more involved in GME? We suggest a threefold answer—money, lack of precedent, and a lack of vision on both sides.

Money
Managed care providers and AMCs share common problems with funding. We think that managed care providers and AMCs have areas where personnel and services overlap. Moore lists some of these overlaps as pay for teaching for managed care physicians, fees for service arrangements for AMC physicians, shared purchase of services, and collaboration on proposals to attract research funding.

Lack of precedence
In this area, managed care providers and AMCs have had a limited arrangement. As Corrigan and Thompson reported, the primary contractual arrangements involving managed care and AMC personnel have been fee-for-service arrangements. A need exists for managed care providers and AMCs to get together and attempt to identify some common objectives, especially regarding GME. The use of one another’s personnel and even possible staff exchanges are just two ways in which resources can be pooled and savings incurred. We endorse Moore’s notion that small beginnings that result in positive experiences are an excellent start.

Lack of vision
Given the complexities of the emerging health-care system, concerted action by both AMCs and HMOs is required. So too is the requirement for COMs to take the lead in certain areas where only an integrated managed care-GME system can succeed. Retraining of physicians is one example. As Mullan and colleagues indicate, physicians have a 40-year projected work life. Thus, changes in educational outcomes will slowly affect the physician specialty mix. According to these researchers, if 50% of residents graduate as generalists in 1994, it will take until the year 2040 for the physician workforce as a whole to reach the desired 50% ratio of generalists to specialists. Retraining of specialists and international medical graduates is one logical way to approach the generalist physician shortage issue. Retraining of general physicians is clearly one area where collaboration between managed care providers and AMCs brings together the two segments of the medical community best suited for the task.

We also think that both osteopathic and allopathic medical schools have an obligation to prepare their graduates to practice in or be competitive for jobs in primary care settings. We agree with Whyte and Cantor that medical students need to be taught in managed care systems. It is unrealistic to assume that students will learn these skills on-the-job in managed care settings. Part and parcel of this argument is the need to introduce management and other managed care specific skills into undergraduate and graduate medical educations.

Comment
Healthcare reform, most likely in the form of managed care, is on the way. Academic medical centers must make every effort to develop collaborative arrangements with managed care programs, such as HMOs. These entities must get beyond their perceived barriers and realize that they have mutual interests. Clearly, AMCs need new ambulatory care sites and teachers to complement in-hospital teaching. Likewise, as HMOs expand, they will need physicians to staff their facilities. Therefore, HMOs that become involved in medical education will have a built-in base from which to recruit physicians for employment in their managed care networks.

Primary care physicians will play a pivotal role in healthcare reform. With a strong tradition of graduating a large percentage of primary care physicians, COMs are poised to fill the needs of managed care organizations. As such, HMOs and COMs will share a common foundation—providing primary care. The osteopathic medical profession would do well to establish and solidify this symbiotic partnership soon.

References


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