

Executive Summary

This fourth and final major report of the Pew Health Professions Commission comes at the end of the most dynamic decade ever faced by the nation's health professionals. As disruptive as this period has been, however, it may only have been the prelude. The health care system in the US will continue to change. It can only be hoped that in so doing it will respond to the challenge of delivering care that is of the highest quality, but responsible in the way that it uses resources. To do this, health professionals must continually reconsider, in fundamental ways how they may best add value to the delivery of health services.

To succeed in this new world the professions and their leadership must learn to balance individual needs with system and population constraints. The regulatory system for health professional practice must be reinvented to ensure the highest level of practice from professionals. In some instances this will mean learning new skills and practicing in new ways. It may also mean giving up some of what has been valued in the past. Finally, it means aligning the size of the professions to meet public purposes.

Four challenges have informed the Commission's work from its inception and remain at issue today.

First, the nature of health care work is being reconsidered. As health systems struggle to reach new thresholds of lower costs and higher quality, the health care workplace is demanding new professional skills and new configurations of staff including, in some cases, reductions in the numbers of practitioners needed. This will be an involved and creative undertaking that will tax the traditional mindset of the professional. As the system pushes for outcomes at the level of populations and large health care organizations, the professional community must develop the capacity to contribute meaningfully or run the risk of losing their autonomy and influence.

The second challenge will be to restructure the ways in which health care professionals are regulated, in order to promote responsive independence and insure that professional credentials fit with the goals of the emerging system. The Pew Commission has recently released a major report detailing its recommendations in this area,¹ but the three most important elements are: 1) public representation in the regulatory process; 2) testing for continuing competence; and 3) flexibility to practice in those domains in which one has in

fact demonstrated competence. The rules and regulations that govern health care practice are vestiges of the last century. They need to reflect the realities of the world as we enter the new century. To many health professionals the recommendations may appear to be one more effort to constrain their independence. On closer inspection, the Pew Commission hopes that these priorities will be seen by tomorrow's health professional as a form of regulation that ensures the highest levels of public confidence and clinical autonomy. This will only occur by developing new ways of ensuring the public's safety.

Third the Pew Commission has tried to address the concern that professional numbers be sufficient to meet the needs of the public, yet not oversupplied in a way that produces excess costs or wastes scarce resources. In the past, professional education has expanded on its own accord, attempting to forecast the level of demand. It should be obvious that such efforts have not succeeded. In the future, health professional schools will need to attend themselves more closely to the needs of the emerging system. One way to do that would be to align themselves with particular care delivery systems, in order to develop a sense of the numbers of practitioners needed. This task should be one that actively involves professional associations, educational programs and the delivery system itself.

Finally, professional schools must lead the effort to realign training and education to be more consistent with the changing needs of the care delivery system. The Pew Commission's fourth and final report offers recommendations that affect the scope and training of all health professional groups, as well as a new set of competencies for the 21st Century. As in the past, the Pew Commission urges health professional faculty to review their current curriculum against these recommendations and competencies. In general, the recommendations encourage enlargement of the health professional's education to include a broader set of system, organizational and population skills. This change will not be an easy one for most health professional schools, but they are essential for effective practice in the future.

Recommendations for All Health Professional Groups (Chapter III)

RECOMMENDATION 1 Change professional training to meet the demands of the new health care system.

In spite of the dramatic changes affecting every aspect of health care, most of the nation's educational programs remain oriented to prepare individuals for yesterday's health care system. They have not assimilated the new values, techniques, and skill sets required to pursue a satisfying and thriving practice in the managed care world. Curricula for doctors, nurses, and allied health professionals must redirect their efforts to ensure that their graduates will be successful in the types of professional practice environments and organizations that are just emerging. To assist in this process the Pew Commission has revised the set of competencies that it developed in 1993 and now offers twenty-one competencies for successful practice in the twenty-first Century. The list of competencies immediately follows this section. The specific action steps for Recommendation One are:

- Professional school faculties and administration should evaluate their current course of study to determine whether or not they are adequately preparing students to meet the challenges set forth in the competencies.
- Professional associations should integrate the competencies into their accreditation and licensing processes, benchmarks for graduation, entry into professional practice and continuing competence.
- Students should assess the quality of educational programs based on how well they will prepare them to apply the competencies in their careers.
- Hospitals and other institutional providers should prefer partnerships with academic institutions that continuously revise their curricula to reflect changing market dynamics and that embody the competencies.

RECOMMENDATION 2 Ensure that the health profession workforce reflects the diversity of the nation's population.

The next generation of health professionals should represent the nation. Not only would renewed commitment to diversity be the fairest way to accommodate all potential medical practitioners, it would be in the best interest of those parts of the population that bear the greatest burdens of poor health. Students that come from medically underserved communities have demonstrated a much greater willingness to return to them to practice. By knowing the language and cultural mores of the population they serve, they offer a more complete and effective kind of care. A key challenge of the next century will be to apply our system's focus on achievement in the basic sciences to the widespread and equitable distribution of health care resources. One way to accomplish this is by attracting new types of students to the professions. Admissions standards should be established at a level that will ensure that the intellectual material needed to become a health professional can be mastered by the student. Such standards will rightly vary considerably across individual schools. Beyond that standard, admission should be established around the principle of representation and service. It is essential that the nation's health profession workforce represent the cultural diversity that is and will become an even more significant part of this society. This is not a quota borne out of a sense of equity or distribution of justice, but a principle that the best health care is delivered by those that fully understand a cultural tradition. To create such a workforce the following actions must be taken:

- Admissions policies in professional schools must supplement their academic standards for entry with other criteria for admission such as ethnicity, cross-cultural experience and commitment to community service.
- Universities and academic health centers should actively engage the broader K-12 educational system to provide early exposure to the sciences and the health professions to populations who are under-represented in those fields.

RECOMMENDATION 3 Require interdisciplinary competence in all health professionals.

This competency is listed among the twenty-one, but is so essential for the future that it is emphasized here. Today's best integrated health delivery systems are evolving toward a model of care in which interdisciplinary teams of providers manage the care of the sickest patients. This model, which involves physicians, nurses, and allied professionals, is proving its worth with both acutely and chronically ill patients. Resources are used in the most timely and efficient way; mistakes or duplication of services is avoided; and the expertise and instincts of a number of trained health practitioners are brought to bear in an environment that values brainstorming, consultation, and collaboration. This is not a value that has been inculcated in health professional training programs of the past. Medical and professional schools should fundamentally reassess their curricula to ensure that their programs embody and apply an interdisciplinary vision.

- Care delivery systems should work with local educational programs to describe and demonstrate how interdisciplinary skills are being incorporated into practice.
- Schools and faculties should target 25 percent of their current educational offerings that could more efficiently and effectively be offered in interdisciplinary settings.
- Students should seek their own opportunities to study or work in environments that expose them to interdisciplinary care as early as possible.

RECOMMENDATION 4 Continue to move education into ambulatory practice.

The health care system has traditionally trained doctors in hospital settings, while the health care system is moving health care out of the hospital. Students need to be exposed to ambulatory settings early in their training. This movement has been underway for some time, but there is a long way to go.

- Care delivery systems should audit their current commitments to education, develop ways of cost sharing and promote effective integration of education and practice.

- Schools and faculties should assess what has been done to date, identify barriers to further movement and develop partnerships with the care delivery systems to help enhance the quality and amount of education in ambulatory settings.

RECOMMENDATION 5 Encourage public service of all health professional students and graduates.

The nation and its health professionals will be best served when public service is a significant part of the typical path to professional practice. Educational institutions are the key to developing this value.

- Health professional programs should require a significant amount of work in community service settings as a requirement of graduation. This work should be integrated into the curriculum.
- Students should assist in the design and development of such programs.
- Communities and the health agencies that serve them should actively participate in the partnerships through which these service programs can be built.
- Existing programs of national service tied to debt forgiveness should be expanded and enlarged in order to incorporate more health professional graduates.
- Professional associations should actively incorporate the idea of public service into regulation and professional development activity.

Twenty-one Competencies for the Twenty-First Century (Chapter IV)

1. Embrace a personal ethic of social responsibility and service.
2. Exhibit ethical behavior in all professional activities.
3. Provide evidence-based, clinically competent care.
4. Incorporate the multiple determinants of health in clinical care.
5. Apply knowledge of the new sciences.
6. Demonstrate critical thinking, reflection, and problem-solving skills.
7. Understand the role of primary care.
8. Rigorously practice preventive health care.
9. Integrate population-based care and services into practice.
10. Improve access to health care for those with unmet health needs.
11. Practice relationship-centered care with individuals and families.
12. Provide culturally sensitive care to a diverse society.
13. Partner with communities in health care decisions.
14. Use communication and information technology effectively and appropriately.
15. Work in interdisciplinary teams.
16. Ensure care that balances individual, professional, system and societal needs.
17. Practice leadership.
18. Take responsibility for quality of care and health outcomes at all levels.
19. Contribute to continuous improvement of the health care system.
20. Advocate for public policy that promotes and protects the health of the public.
21. Continue to learn and help others learn.

Recommendations for the Professions (Chapter V)

A. RECOMMENDATIONS FOR ADVANCED PRACTICE NURSING

A1. Reorient advanced practice nursing education programs to prepare APNs for the changing situations and settings in which they are likely to practice.

- Prepare APNs to translate a core set of skills across institutions and settings, managing persons with health care problems regardless of their location.
- Expand the proportion of advanced-practice nurse training sites in ambulatory and long-term care settings favored by managed care systems.

A2. Regardless of payer source (HCFA or an all-payer pool), federal funding for graduate medical education should be made available to support the training of advanced-practice nurses and other non-physician providers in clinical settings.

- Pay funds directly to the clinical service site providing APN training and not to the educational programs that are responsible for planning education.
- Develop a mechanism to ensure that this funding does not create an unwarranted expansion of the total number of training positions for APNs.

A3. Develop standard guidelines for advanced nursing practice and reinforce them with curriculum guidelines, examination requirements, and accreditation regulations.

- Establish standards for interdependent vs. autonomous practice, prescriptive authority, hospital admitting privileges, civil liability, and other critical areas.
- Gather input from a broad set of health disciplines to ensure that guidelines reflect the diversity of APN practice in the delivery system.

A4. Emphasize the practice styles that are a critical part of advanced practice nursing, including the emphasis on preventive and health-promoting interventions and attention to psychosocial, environmental, and resource factors.

- Support research to examine the effect of these practice characteristics on outcomes in the populations served by emerging health care networks.
- Enhance the research training of APN students to ensure that future APNs have the background to evaluate and advocate for effective practice styles.

B. RECOMMENDATIONS FOR ALLIED HEALTH

B1. Create incentives for public and private employers of allied health services to support outcomes-based research on allied health practices.

- Combine funds from state, education, and industry partnerships.
- Ensure that the process is competitive and peer reviewed.

B2. Create partnerships of educators, employers, and workers to identify and standardize auxiliary health competencies that are learned on the job.

- Establish a core set of competencies that cut across the auxiliary occupations, such as knowledge of basic medical terminology, ability to communicate in a health care setting, and an understanding of health workplace safety.
- Build upon this core by delineating more specific guidelines for different auxiliary health occupations and tie these definitions to career ladders.

B3. Facilitate the continuous retraining of allied health professionals.

- Create links across different practice arenas within allied health.
- Create local education-health delivery partnerships for articulations and linkages.
- Connect continuous competencies with relicensing processes.

C. RECOMMENDATIONS FOR DENTISTRY

C1. Promote and develop opportunities for cooperation between dentistry and medicine that will integrate oral medicine into comprehensive patient management.

- Integrate the training of dental and medical students at the undergraduate and graduate levels and explore options for integrating dentistry as a medical specialty.

- Create required and optional clerkships for dental students in areas of medicine that are relevant to dental care, such as emergency medicine, pediatrics, and geriatrics.
- Ensure that physicians who are training to be generalists receive adequate exposure to issues in oral health and train them to work with dentists effectively.

C2. Redesign dental schools' curricula to focus on critical competencies for integrated care and support them with accreditation and licensing standards.

- Set explicit targets and time-tables for modernizing courses and eliminating marginally useful material in order to shift emphasis to clinical thinking and problem-solving skills.
- Redesign dental licensure examinations to increase the emphasis on disease and physiology and to support dental schools' orientation toward comprehensive care.

C3. Develop and expand the relationship between dentists and allied dental workers.

- Encourage the development of new roles for dental hygienists, assistants, and laboratory technicians in providing basic dental services under the supervision of dentists.
- Train dentists in the management and communication skills necessary for providing leadership in dental and health teams with multiple types of professionals.

D. RECOMMENDATIONS FOR MEDICINE

D1. Use government subsidies to create incentives for reducing specialist residency positions and maintaining adequate numbers of generalist residency positions.

- Require teaching hospitals receiving public reimbursement to maintain at least as many generalist residency positions as are currently available.
- Reimburse teaching hospitals for adding positions in generalist programs only if these increases are offset by reductions in specialty positions.

D2. Continue current public and private initiatives to encourage physicians to practice in underserved areas and explore new strategies to address this challenge.

- Expand programs such as the National Health Service Corps which partly subsidize medical students' debt in exchange for service in underserved areas.
- Encourage undergraduate and graduate medical education programs to include a mandatory service-oriented rotation in underserved communities.

D3. Expand current mechanisms for moving general internal medicine, family practice, psychiatry, gynecology, and pediatrics clinical clerkships to non-hospital sites.

- Distribute indirect medical education payments among teaching hospitals, non-hospital teaching sites, and affiliated academic institutions.
- Focus research on determining the most appropriate percentages, as well as mechanisms for estimating costs associated with education in non-hospital settings.

D4. Explore strategies for tracking medical students at an earlier stage into four basic fields: primary care, sub-specialty care, research, and administration.

- Develop a consensus among educational leaders about the core of knowledge and skills that are needed by all physicians regardless of practice area.
- Establish clearly-defined boundaries for educational tracks associated with the basic fields of primary care, sub-specialty care, research, and administration.
- Create elective opportunities within undergraduate programs for medical students to spend a minimum of six months to a year gaining on-site experience in one of these fields.

E. RECOMMENDATIONS FOR NURSING

E1. Adjust education programs to produce the numbers and types of nurses appropriate to local or regional demand, rather than institutional and political needs.

- Implement aggressive recruitment and retention efforts to increase the enrollment and graduation of under-represented minorities, especially at higher degree levels.
- Target high school and early college level students for entry into undergraduate nursing education programs in order to reverse the trend in workforce aging.

E2. Delineate the knowledge and outcome competencies appropriate for each level of nursing education in order to maximize efficiency, improve coordination and articulation of programs, and reduce professional conflict and public confusion.

- Continue to downsize or merge diploma programs with college or university-based programs, while increasing admissions to baccalaureate programs.
- Expand and strengthen existing career mobility programs to facilitate educational advancement for associate degree and diploma-credentialed RNs.

E3. Radically revamp the content and learning experiences in the nursing curriculum to produce graduates with the competencies needed for differentiated practice.

- Increase the proportion of learning experiences in ambulatory, long-term care, and community-based setting at all appropriate levels of nursing education.
- Refocus higher degree programs on group management skills, clinical management skills, technological capabilities, critical thinking, and professional judgment.

E4. Integrate the research, teaching, and practice enterprises of nursing education programs in order to further nursing's professional and practical goals.

- Recruit nurses with extensive practice experience, particularly in integrated systems of care, to teach in diploma/associate degree programs.
- Expand the opportunities for faculty in baccalaureate and higher degree nursing programs to participate in clinical research, and reward them for doing so.

F. RECOMMENDATIONS FOR PHARMACY

F1. Continue to orient pharmacy education to reflect pharmacists' changing practice roles and settings under managed care and in clinical drug therapy.

- Adjust curricula to provide students with the skills in population management, epidemiology, pharmacoconomics, outcomes measurement, health services research, and health care organization that are demanded by emerging systems.

- Encourage pharmacy schools to become more active partners in residency training and expand training sites to more ambulatory and managed care settings.

F2. Embrace an interdisciplinary approach to health care delivery.

- Re-focus educational programs to prepare students in the team-building and management skills that will allow them to work smoothly with other providers.
- Foster collaboration with pharmacy technicians and other allied health workers and encourage them to contribute to patient care to their full capacity.

F3. Provide opportunities for re-training and continuing education for practitioners to develop skill sets for expanded clinical roles beyond dispensing pharmaceuticals.

- Continue to explore nontraditional, distance-learning techniques, including written materials, videotapes, interactive television, and the Internet.
- Take advantage of opportunities to provide greater exposure to managed care organizations and chain pharmacy settings in re-training programs.

G. RECOMMENDATIONS FOR PHYSICIAN ASSISTANTS

G1. Incorporate concepts including population-based care, accountability, outcomes information, professional interdependence, and linkages between health care delivery and finance into physician assistant education and training.

- Search for ways of adding concepts to existing course and clinical work in educational programs without extending the current length of PA education.
- Focus national leadership on developing accreditation standards that encourage PA training programs to incorporate appropriate principles in the curriculum.

G2. Federal funding for graduate medical education should be made available to support the training of physician assistants and advanced practice nurses in clinical settings.

- Pay funds directly to the clinical service site providing physician assistant training and not to the educational programs that are responsible for planning education.

- Develop a mechanism to ensure that this funding does not create an unwarranted expansion of the number of training sites for physician assistants.

G3. Affirm the physician/PA relationship as it was created and has existed, rather than re-defining it to give the PA a more isolated role from the physician.

- Project physician assistants into emerging manage care practice models in ways that maintain the traditional values and intent of physician/PA collaboration.
- Develop new models for expanded physician practice which effectively utilize physician assistants and other non-physician practitioners.

H. RECOMMENDATIONS FOR PUBLIC HEALTH

H1. Each state should undertake a broad assessment of its public health workforce in order to facilitate workforce planning and training.

- Using a standard taxonomy of professions and occupations, this assessment should target the multiple sectors in which essential services are delivered, to identify the type of service performed, the profession or occupation in the position, and the competencies necessary to perform the work effectively.
- Several entities in a state could lead or collaborate in such an assessment, including the state, public health or medical schools, consortia of local departments, or the community college system.

H2. Public health schools and departments should develop certification and continuing education programs to help public health providers upgrade and maintain their competence.

- These programs should be in the important knowledge and technical skill areas (such as epidemiology, social marketing, administration, environmental health) that can be delivered flexibly (such as distance learning) to workers in both the public and private sectors.
- Government, at both the federal and state level, should budget resources for the continuing education of the public health workforce.

H3. Public health curricula and training in both schools and individual programs should expose students to, and prepare them for, the multiple sectors in which public health services are delivered.

- Schools and programs should recruit, retain and value faculty with a broad set of experiences in various types of health care delivery settings.

H4. Public health departments, schools and professions should urge other professions and organizations in assessing and promoting the public's health.

- Schools and programs should develop educational and research programs that actively involve other professions and organizations that provide population-based services, including integrated delivery systems.
- Accreditors of health professions education (e.g. - Liaison Committee for Medical Education, National League for Nursing) should consider including public health courses and competencies in their accreditation requirements.

H5. Public health schools, programs and departments should focus some of their resources on training lay health workers and community residents to understand the mission of public health and equip them with the basic competence to accomplish this mission.

- Schools and programs should develop training programs that target those persons working in public health who do not have training and could benefit from focused certification programs.
- Private sector organizations involved in public health should also invest resources in training a competent workforce.

Public Policy Recommendations (Chapter VI)

Recommendations for ACCREDITATION

1. Educational institutions, programs and accreditors should recognize their shared responsibility for responding to the changing needs and demands of the public, employers, professional bodies and students.

- Establish broad competencies needed for practice through a collaborative approach among educators, professional organizations and employers and an on-going assessment of changing practice needs.
- Integrate the accreditation process into a larger system of program review, improvement and regulation. While some relationships exist among the various parts of this system (professional regulation, individual licensure and certification, organizational accreditation, peer review, state review, etc.), there appear to be cases of overlap and duplication of effort.

2. Educators and accreditors should work together to foster continuous assessment and improvement.

- Articulate accreditation in the context of current practice and the anticipated future directions.
- Actually commit to making improvement a part of the daily work of institutions. This would make accreditation more of a process than a series of burdensome external mandates.

3. The accreditation process should encourage creative methods and measures to enhance efficiency, minimize waste and duplication, and streamline assessment processes.

- Streamline the accreditation process to increase accountability and minimize duplication and waste.
- Restructure site visits as focused reviews, emphasizing opportunities for constructive consultation.

- Increase flexibility and responsiveness of the process by integrating contemporary technology and relying upon more electronic communication and other resource-conserving approaches.

4. A consistent “5+1 criteria” approach for accreditation should be adopted by all specialized and professional accrediting agencies, consisting of five common criteria and one profession-specific criterion.

- Base accreditation on the following areas:
 - Connection of the community of practice and the public to prepare the workforce for the relevant community needs/assets;
 - Appropriate, periodic and ongoing faculty development and evaluation;
 - Assessment of the competencies and achievements of its students and graduates;
 - An effective process of continuous self-assessment, planning and improvement; and
 - Representation the public to ensure accountability and consumer choice.
- Each accrediting agency would create one additional criterion that would acknowledge the unique aspects of the profession being reviewed.

Regulatory Boards and Governance Structures

1. Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement.

2. States should require policy oversight and coordination for professional regulation at the state level. This could be accomplished by the creation of an oversight board composed of a majority of public members or it could become the expanded responsibility of an existing agency with oversight authority. This policy coordinating body should be responsible for general oversight of that state’s health licensing boards

and for assuring the integration of professional regulation with other state consumer regulatory efforts (e.g. health facility and health plan regulation).

3. Individual professional boards in the states must be more accountable to the public by significantly increasing the representation of public, non-professional members. Public representation should be at least one-third of each professional board.

4. States should require professional boards to provide practice-relevant information about their licensees to the public in a clear and comprehensible manner. Legislators should also work to change laws that prohibit the disclosure of malpractice settlements and other relevant practice concerns to the public.

5. States should provide the resources necessary to adequately staff and equip all health professions boards to meet their responsibilities expeditiously, efficiently and effectively.

6. Congress should enact legislation that facilitates professional mobility and practice across state boundaries.

Scopes of Practice

7. The national policy advisory body recommended above should develop standards, including model legislative language, for uniform scopes of practice authority for the health professions. These standards and models would be based on a wide range of evidence regarding the competence of the professions to provide safe and effective health care.

8. States should enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body.

9. Until national models for scopes of practice can be developed and adopted, states

should explore and develop mechanisms for existing professions to evolve their existing scopes of practice and for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health care practice. These mechanisms should include:

- Alternative dispute resolution processes to resolve scope of practice disputes between two or more professions;
- Procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and
- Comprehensive legislative “sunrise” and “sunset” processes that ensure consumer protection while addressing the challenges of expanding existing professions’ practice authority, and regulating currently unregulated healing disciplines.

Continuing Competence

10. States should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.

Recommendations for REFORMING FEDERAL GME POLICY

1. All-Payer Financing

An all-payer pool should be established to ensure that both public and private beneficiaries of medical education contribute to the subsidization of clinical education for physicians, APNs, and PAs. This pool should be financed via a per-capita assessment on health plan enrollees (managed care and fee-for-service, including self-funded plans) and contributions from Medicare and other federal programs that subsidize GME. Revenues from both public and private payers should be deposited into a trust fund dedicated exclusively to funding clinical education for physicians, APNs, and PAs.

- All entities providing clinical education would be eligible for all-payer payments (including consortia and children’s hospitals).

- A uniform per-resident payment formula should be established under which the per-resident component of DME payments would vary among teaching hospitals in only a limited fashion by external factors such as regional variation in cost of living.

2. Number of Positions Funded

The Commission believes the BBA does not provide sufficient incentives to reduce the number of physicians trained in the U.S. to an appropriate level. Thus, the Pew Commission recommends that more stringent controls be established for allocation of funds from the all-payer pool.

- Set the number of all-payer funded residency positions at a level no greater than the number equivalent to 110 percent of the number of U.S. medical graduates (allopathic and osteopathic) in 1997, a reduction of 25 percent from the current number of federally subsidized first-year residency positions.
- The provisions of the BBA that cap the number of Medicare-funded positions at individual teaching hospitals should be applied to all-payer financing.

3. Eligibility for Funding

- Guarantee all-payer reimbursement for all U.S. medical graduates who have passed parts I and II of the U.S. Medical Licensure Examination or the Comprehensive Osteopathic Medical Licensing Examination and who are admitted to an accredited residency program.
- Develop a mechanism for allocating all-payer funding for a number of positions equivalent to the size of U.S. medical graduates plus 10 percent to subsidize the training of U.S. citizens and permanent residents educated in international medical schools. In developing this mechanism, policymakers must confront a major tradeoff between advancing educational principles and preserving institutions that have depended on IMGs to provide uncompensated care.

- Eliminate GME payments for IMG residents who are citizens of other nations but continue to permit them to complete GME in the U.S., provided their training is subsidized via foreign aid, their home governments, or private funds.
- With regard to non-citizen IMGs, the Commission reiterates its recommendation that U.S. immigration laws be tightened to ensure that foreign nationals return to their home countries upon completion of residency training.

4. Incentives for Training Physicians in Generalist Disciplines

Two policies are needed to enhance existing strategies aimed at ensuring that the U.S. has an adequate supply of generalist physicians.

- Require teaching institutions that receive all-payer GME payments to continue to maintain the number of generalist residency positions they made available in 1997.
- Provide DME payments only for residents completing minimum requirements for initial board eligibility.

5. Indirect Medical Education (IME) Payments

The provision of the BBA which phases in a reduction in the IME adjustment percentage from 7.7 to 5.5 percent over a five-year period and caps the number of residency positions and the ratio of residents to beds should be applied to disbursement of all-payer funding for IME. Indirect Medical Education expenses go to institutions to pay for higher acuity levels of patients seen and the complexity of care delivered. Eligibility for IME payments should be consistent with eligibility for DME payments. Two additional modifications in IME policy are needed.

- Create a separate mechanism for payment of IME that is independent of payments for inpatient hospital services. Establish a separate system of prospective payment for indirect expenses associated with medical education under which payments would be divided among teaching hospitals, affiliated academic institutions, and non-hospital training sites. Work should commence immediately to develop formulas for allocating IME to non-hospital sites.

- Base a significant proportion of IME payments to teaching hospitals on historical IME revenues rather than the current ratio of full-time equivalent residents to beds.

6. Preserving Access to Care for the Uninsured

Since its inception, the Pew Commission has advocated universal access to health insurance for all Americans. Expanding access to health insurance constitutes the most rational and appropriate approach to ensuring access to care. The Pew Commission is encouraged by recent incremental efforts to address this problem but recognizes that today many persons remain uninsured and that some of them, particularly those living in inner-city areas, depend on teaching hospitals for medical care. Recommendations for reform of federal GME policy must take the needs of this vulnerable population into account.

Developing GME reforms that do not compromise access to care for the poor is a formidable challenge but one from which the nation cannot shrink. For too long, concerns about institutions providing high levels of uncompensated care have posed a roadblock to major reform of GME policy. As the new millennium dawns, we must pursue strategies that address both sets of concerns in a rational and equitable manner.

- The Commission supports the provisions of the BBA that provide transition assistance to teaching hospitals that voluntarily reduce the number of residents they train.
- The Commission strongly recommends expansion of the National Health Service Corps' loan repayment program and modification of its eligibility criteria to facilitate participation by specialists where needed. This recommendation is an essential component of a comprehensive GME reform strategy, because it would provide a replacement workforce for communities that have depended on residents to deliver care to underserved populations.

7. Funding for Advanced Clinical Education of Nurse Practitioners and Physician Assistants

To promote a multi-disciplinary and flexible primary care workforce and ensure that APNs and PAs have adequate access to appropriate clinical training sites:

- Eliminate the Medicare subsidy for diploma nursing education programs.
- Create a new all-payer subsidy for clinical education of APNs and PAs.
- Cap number of APN and PA positions funded at the number of full-time equivalent students enrolled in 1997.

8. Federal Workforce Policy Commission

Finally, a new commission should be established and appropriated sufficient resources to track health care workforce trends and advise Congress, the President, and the U.S. Department of Health and Human Services regarding the all-payer pool and other health professions workforce policies. This new commission also should collect, analyze, and disseminate data about supply and demand for health professionals. The members should represent a broad cross-section of interested parties, including consumers, health professionals, health professions educators, and organizations involved in the financing and delivery of health care services. The commission should be a public-private partnership, in recognition of the contributions of private payers to the all-payer pool. This new commission is needed because no existing body is equipped to carry out this charge. Although Congress has directed the Medicare Payment Advisory Commission and the National Bipartisan Commission on Medicare to address Medicare GME policy, the mandates of these commissions are too broad to permit them to examine GME policy in depth. Existing workforce policy bodies, such as the Council on Graduate Medical Education are under-funded and focus too narrowly on a single profession.