



## EDITORIAL

# Reforming a Health Care Workforce

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After 100 years of political debate—rancorous to the very end—last month the U.S. committed to providing health care insurance coverage to all citizens by passing the Patient Protection and Affordability Care Act<sup>1</sup>. Guaranteeing financial access to care within the U.S., something long done in many other countries, is the culmination of efforts dating back to the presidency of Teddy Roosevelt in the early days of the last Century. Finally now affirming people’s right to health care confirms Winston Churchill’s observation, “You can always count on Americans to do the right thing - after they've tried everything else.”

But guaranteed health insurance was only one thrust of the new health care reform law. Less public attention has been given to the law’s many provisions designed to alter the composition, geographic distribution and skill sets of the health care workforce. The goals of the workforce programs and incentives created by the law are to promote health care quality and access beyond that possible through insurance reform alone. Below, we list some of the law’s workforce provisions, especially those that will affect the education and the early careers of practitioners.

Among the provisions targeting health care education institutions, the health care reform law provides a new grant mechanism to help medical schools create and expand programs to train students for the unique demands of practice in rural and underserved settings. Eligible programs must give admissions priority to students with rural backgrounds and must provide didactic, clinical and group experiences appropriate for preparation for rural medical practice. Grant funding priority will be given to programs that partner with community-based organizations. The health care reform law also provides new funding for residency programs in Preventive Medicine, a recognized specialty in the U.S. that couples medical and public health training and is often pursued by those preparing for careers in public health leadership and administration. Another provision of the law stipulates that federal dollars that support the training of primary care residents can, for the first time, be paid directly to outpatient clinical practices to cover the added costs of teaching, thus removing a longstanding barrier to outpatient-based training. The law also provides new funding to construct buildings within states’ sole public medical and dental schools.



Costs and financial borrowing for an education in all health professions in the U.S. have risen sharply over the past decades. Debt on graduation now routinely exceeds \$150,000 and even \$200,000 for physicians, dentists and pharmacists. Various provisions of the health care reform law leverage the financial debt burden graduates carry by expanding and creating wholly new programs that promise to repay a portion of young clinicians' loans if they practice in shortage-area locations and disciplines. The law expands the venerable National Health Service Corps, a program that repays educational loans for primary care, mental and dental health practitioners who work in designated shortage areas. The law creates new loan repayment programs to meet recognized workforce shortages in public health, allied health and the pediatric medical subspecialties. Just as importantly, another provision of the new law now exempts from federal income taxes the funds practitioners receive when participating in loan repayment programs offered by individual states, effectively increasing the value to participants of payments from these programs by around 25%, the typical federal tax rate.

In a country where deliberate health workforce planning has long been treated as an anathema, the health care reform law creates a National Health Care Workforce Commission. This new body is to serve as a source of information and recommendations for the Congress, President and states on topics like workforce shortages and the anticipated effects on the health care workforce of current and potential future public policies. The law also establishes a National Center for Health Care Workforce Analysis to fund state and regional analysis centers and otherwise contract for specific needed analyses. The law further establishes a grant program to support states' own workforce planning and initiatives.

From an international perspective, there may be little unique or groundbreaking about the universal health insurance coverage provisions of the U.S.'s much touted health care reform law. Similarly, many of its health workforce provisions pursue strategies already used in other countries. And just as the health insurance "reform" provisions of this law do not fundamentally change the U.S. health care payment system, which remains based on private insurance, so the health care workforce provisions do not change the system's fundamental reliance on subspecialty practitioners. Nevertheless, rarely do large countries pass sweeping laws creating so many new programs and incentives to influence key components of the training and distribution of a health care workforce. We find great promise in these collective workforce provisions. For a change, other countries may find something within U.S. health policy worth emulating.

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## Reference

1. The Patient Protection and Affordable Care Act. December 24, 2009. Available at <http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf> Accessed April 3, 2010.