Family Practice Forum

Federal Support for Family Medicine

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Federal support has been a major factor in the development of family medicine in the 1970s. As budgets become tighter in the 1980s, the role of family medicine in addressing national health priorities will be examined, and it will be necessary to establish justification for further support.

In the generation following World War II, American medicine witnessed a dramatic increase in specialization. This was accelerated by increased biomedical research, largely through the National Institutes of Health (NIH), and by the concurrent increased availability of fellowships. Organized medicine also encouraged specialization through the recognition of subspecialty and fellowship training as contributing toward board eligibility in pediatrics and internal medicine.

In the 1960s, health manpower deficits began to attract the attention of policymakers. Demands for access to high quality primary care services in both urban and rural settings were growing faster than supply. Major factors in the decreased availability of primary care services included the aging cohort of general practitioners in rural communities and the tendency of younger physicians to specialize in areas other than general practice and to contribute to geographic maldistribution.

In 1965, the passage of legislation for the entitlement programs (Medicaid/Medicare) increased demand for services and also raised doubts about the overall adequacy of the supply of health professionals.

Beginning in the 1960s, major interventions utilizing public monies concentrated on stimulating the supply of health professionals through such programs as capitation, start-up for new health professions schools, financial distress assistance for schools, and construction.

Attention was also directed toward the development of primary care programs, including curriculum and team development, interdisciplinary training, ambulatory training sites, nurse practi-

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tioner and physician's assistant training, and primary care residencies. Initially, some of the curriculum development projects, undergraduate programs, and residencies were funded as contracts with the federal government or foundations. Other programs designed to affect the behavior and location of health professionals included the National Health Service Corps (NHSC), the NHSC Scholarship Program, and educational support for underserved communities (the Area Health Education Center Program).

By 1970, the focus of the primary care movement was increasingly directed toward family medicine. Although initial federal monies were concentrated on curriculum development and undergraduate programs, it became apparent that without strong postgraduate training and faculty support, the impact of curriculum development was minimal.

Currently, family medicine enjoys a full spectrum of support from federal monies, including curriculum development, faculty enrichment, development of departments of family medicine, and residency training programs.

Federal support for family medicine has had a significant impact on the character of medical education and postgraduate education. The extent of this federal support is evidenced by the following statistics.

1. Since 1972, $144 million has been awarded to 281 different programs for graduate training in family medicine.
2. In each year since 1972, 31 to 66 percent of approved allopathic family practice residency programs have received federal funds for graduate training.
3. Of the 6,666 graduates of allopathic family practice residencies from 1969 to 1979, 6,051 (91 percent are from programs which have received federal funds for graduate training.
4. There has been $18 million awarded to 47 schools for predoctoral training since 1978.
5. There has been $9 million awarded to 30 programs for faculty development since 1978.
6. During 1978-1979, 1,562 physicians were trained in federally funded faculty development programs.

The consistency of the legislative support of family medicine can be traced to the 1960s and the policymakers' desire to assure improved access to care, which was reiterated in the preamble to the current law (PL 94-484):

> The Congress finds and declares that . . . the availability of high quality health care to all Americans is a National goal (and) the availability . . . is, to a substantial extent, dependent upon . . . the availability of adequate numbers of physicians engaged in the delivery of primary care, including family practice. . . .

The expiration of PL 94-484 in September 1980 and the associated discussion of the direction and emphasis of the support for family medicine provide both the opportunity and necessity for reexamination of the place of family medicine in our national health priorities. With health expenditures approaching and surpassing ten percent of the gross national product, federal monies, especially discretionary funds, will become harder to find. All programs receiving such funds will be under close scrutiny. Policymakers, managers, administrators, and educators appreciate that multiple factors, including admission criteria, the content and setting of educational programs, community factors, and reimbursement policies, affect the behavior of health professionals. Nevertheless, family medicine will need to demonstrate that its graduates are contributing to the improvement of access to quality health care for all Americans; and that it is thereby addressing our national health priorities and is deserving of further taxpayer support.

In view of the continuing pressure from the constituencies of the Congress to "do something" to improve access to quality health care, Congress is likely to continue to support family medicine for the immediate future. This is evidenced in the five major health manpower bills that have been introduced into this session of Congress. Generally, these bills reflect the ongoing strong support for family medicine, although they differ in approach and emphasis.

Thus, in the absence of stronger or contradictory data, Congress has supported family medicine for ten years on the assumption that such support would alleviate maldistribution and improve access to care. Sufficient time and taxpayer dollars have now been invested, and family medicine can be expected to demonstrate that the logic has been correct and the faith well founded.

The federal government has provided a major impetus to the development of family medicine in the last decade. During the next few years, Congress will be turning to the system that has evolved to supply evidence that further support is justified.