reform law. Many conservatives still advocate "repeal and replace," but the almost-certain backlash against taking coverage away from more than 15 million Americans makes it hard to imagine this rhetoric becoming reality, even if Republicans control Congress and the White House after 2016.

What's likely, then, is health care reform version 1.1, rather than version 2.0. We'll probably see substantial debate over refining the ACA[4] rather than replacing it, much as occurred after the enactment of Medicaid and Medicare in 1965. Perspectives on how to do so will vary; some policymakers will argue that the law isn't generous enough, while others will insist that it's already too costly and intrusive. Ultimately, there are likely to be only incremental changes — which will be warranted, since there's still much to be done to improve coverage and access to care for all Americans.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Department of Health Policy and Management, Harvard T.H. Chan School of Public Health, Boston.

This article was published on October 28, 2015, at NEJM.org.

1. Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. JAMA 2015;314:366-74.
2. Garfield R, Damico A, Cox C, Claxton G, Levitt L. New estimates of eligibility for ACA coverage among the uninsured. Washington, DC: Kaiser Family Foundation, 2015.
3. Sommers BD, Maylone B, Nguyen KH, Blendon RJ, Epstein AM. The impact of state policies on ACA applications and enrollment among low-income adults in Arkansas, Kentucky, and Texas. Health Aff (Millwood) 2015;34:1010-8.
4. Wilensky GR. Improving and refining the Affordable Care Act. JAMA 2015;314:339-40.
5. Dorner SC, Jacobs DB, Sommers BD. Adequacy of outpatient specialty care access in marketplace plans under the Affordable Care Act. JAMA 2015;314:1749-50.

DOI: 10.1056/NEJMp1509462

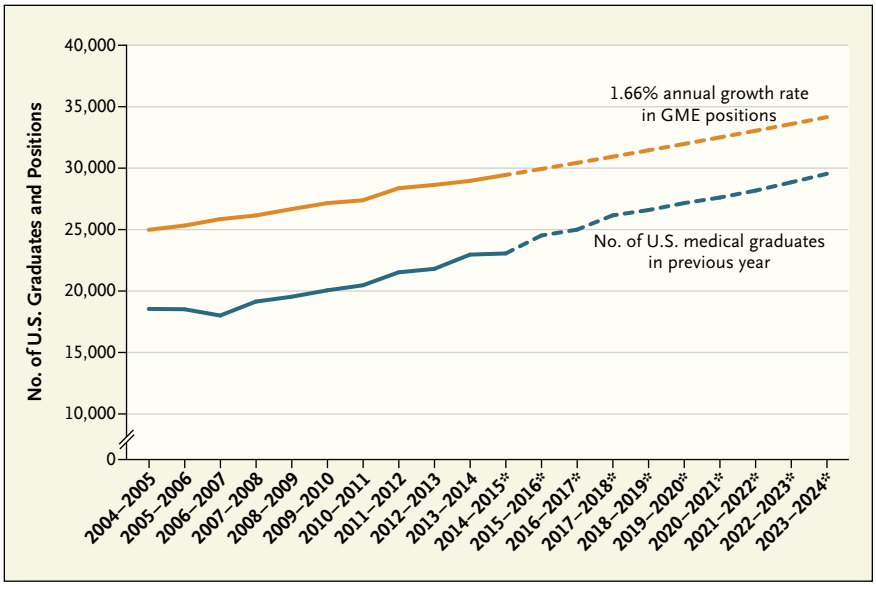
Why a GME Squeeze Is Unlikely

Fitzhugh Mullan, M.D., Edward Salsberg, M.P.A., and Katie Weider, M.P.H.

Between 2002 and 2014, a total of 16 new allopathic and 15 new osteopathic medical schools opened in the United States and many existing schools increased their class sizes,[1,2] for an estimated 49% increase in first-year enrollment nationwide. This explosion in the number of medical students after a long period of level numbers of graduates has raised concerns about the adequacy of the U.S. system of graduate medical education (GME) to provide residency positions for all U.S. medical school graduates. Apprehension about the availability of GME positions is also fueled by the cap on Medicare-funded residency positions, which has been in place since 1997. The specter of insufficient residency slots for U.S. graduates, which would leave some of them unable to obtain licenses to practice medicine, is troubling. What does past growth in numbers of both medical school graduates and residency positions in fact tell us about the future adequacy of GME positions?

Traditionally, there have been many more entry-level positions available than there have been U.S. medical graduates (M.D. and D.O.) to fill them. Large numbers of graduates from international medical schools (international medical graduates, or IMGs) also compete for positions; they include U.S. citizens who study abroad as well as foreign nationals. According to our analysis of data from the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC), and the American Association of Colleges of Osteopathic Medicine (AACOM), between 2004–2005 and 2013–2014, the number of filled entry-level GME positions grew from 24,982 to 28,962, an increase of 3980 positions, or a 1.66% annual rate of growth. During the same period, the number of U.S. graduates with M.D. and D.O. degrees grew from 18,542 to 22,960, an increase of 4418, or a 2.40% annual growth rate. According to the ACGME, there were 6846 entry-level positions filled by IMGs in 2014–2015.

Assuming that the number of GME positions will continue to grow for the next 10 years at the same rate as it has over the past decade, there will be about 34,000 positions available for first-year entrants in 2023–2024. Given AAMC projections through 2021–2022 regarding newly opened M.D. and D.O. medical schools, schools that have been approved to open, and class expansions in current schools,[3] and assuming a continuation of the 2.4% annual



Actual and Projected Growth in Numbers of U.S. Medical School Graduates and Graduate Medical Education (GME) Entrants, Based on 1.66% Annual Growth in GME Positions.

Asterisks indicate projections. Data are from the ACGME, the AAMC, and the AACOM.

growth in 2022–2023 and 2023–2024, the number of graduates in the latter year would be slightly over 29,500 (see graph). Under this likely scenario, there would still be about 4500 more available positions than U.S. graduates in 2023–2024. Although that figure represents a decrease in the gap between GME positions and graduates from 21.7% in 2014–2015 to 13.5% in 2023–2024, the number of GME positions available will continue to substantially exceed the number of U.S. medical graduates seeking them.

This enduring gap suggests that any current or foreseeable failure of U.S. graduates to obtain residency positions is not attributable to a lack of positions. As the gap between the numbers of graduates and positions narrows, there will certainly be more pressure in the residency matching process. For much of the past 50 years, U.S. medical graduates have effectively enjoyed a "selection subsidy," in which the gap has made matching in the specialty and location of their choice less competitive than it would be with fewer excess positions. IMGs, eager to obtain training in the United States, have filled the gap each year, often accepting residencies in specialties less favored by U.S. graduates. Greater competition for residency opportunities may challenge U.S. medical students' traditional assumptions about specialty selection and give new importance to the advice about appropriate specialties provided by medical school faculty and advisors.

Although core dependence on Medicare funding has been a hallmark of GME, the past decade has seen hospitals steadily expand entry-level residency positions despite the Medicare cap. During this period, new positions have been funded by the Veterans Health Administration, the Affordable Care Act Primary Care Residency Expansion Program, and the Teaching Health Center Graduate Medical Education program, as well as by hospitals themselves. States also have contributed to the steady growth in positions by financing GME with direct funds, through Medicaid, or both. In the future, the Veterans Access, Choice, and Accountability Act of 2014 will provide 1500 more training slots; many nonteaching hospitals are starting residency programs that will be eligible for Medicare funding; and in Texas, for example, the legislature provides regular funding for GME ($160 million for the academic years 2015 to 2018).[4]

The more rapid growth in the number of medical graduates than available GME positions described here reveals a trend toward convergence between the two. In the global context, this closer match in numbers has been called self-sufficiency and is regarded as essential for the development of sustainable health systems in all countries. In high-resource countries, self-sufficiency principles call for training consistent with national needs and forgoing perpetual reliance on physician immigration to address shortages. In general, the direction of physician migration has been from poor countries to rich ones, which contributes to depletion and destabilization of the health systems in many low-resource countries. The narrowing of the GME gap in the United States would be an important contribution to attenuating the global brain drain. On the other hand, current legislative proposals backed by the AAMC and others to expand Medicare GME by 15,000 positions would necessarily widen the position–graduate

gap and dramatically increase the demand for IMGs from other countries and for U.S. IMGs who graduate from medical schools in the Caribbean.

The long-term effects of the narrowing U.S. GME gap on the various types of residency applicants (U.S. M.D. graduates, U.S. D.O. graduates, U.S. IMGs, and non-U.S. IMGs) are uncertain. In recent years, nearly all U.S. M.D. graduates have obtained GME positions. Virtually all D.O. graduates, similarly, match to residency programs accredited by the ACGME or the American Osteopathic Association. IMGs (both U.S. citizens and non-U.S. citizens) have fared less well in the competition, with only about half attaining residency positions. The number of U.S. IMGs has grown considerably, and in 2015, these graduates constituted 42% of all IMGs matched to first-year positions in the National Resident Matching Program Main Match.[5] Although U.S. graduates will be affected by the tightening of the gap, the most intense competition will certainly occur among IMG applicants.

Potential effects on U.S. graduates have many members of the educational community worried, and this concern has been passed on to medical students through authoritative warnings that they may have trouble securing residency positions and that their choice of specialties will be severely curtailed. Congress's unwillingness to legislate more Medicare GME funding is often cited as the reason for the perceived squeeze. The positions actually available and the trends reviewed here do not bear out this interpretation. The primary goal of public GME support, it should be noted, is to produce trained physicians to meet the country's health care needs and not to fulfill the personal preferences of individual graduates for the specialties of their choice. Although the GME gap will narrow slowly, it appears likely that there will be ample positions for all U.S. graduates over the next decade. It would seem difficult to argue that Congress should fund more GME positions in order to create a larger margin for U.S. graduates. Disquiet among medical educators is understandable, but we believe that anxiety among students should not be amplified by well-meaning student advisors or national organizations.

The GME system is proving responsive to the increased output of U.S. medical schools. The country would be best served if academic medicine focused its considerable intellect and energies on the task of transforming GME to respond to our rapidly evolving health care system.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the George Washington University Health Workforce Institute, Washington, DC.

This article was published on November 4, 2015, at NEJM.org.

1. Results of the 2014 medical school enrollment survey. Washington, DC: Association of American Medical Colleges (https://www.aamc.org/newsroom/newsreleases/431036/20150430.html).
2. Colleges of osteopathic medicine. Chicago: American Osteopathic Association (https://www.osteopathic.org/inside-aoa/accreditation/predoctoral%20accreditation/Documents/current-list-of-colleges-of-osteopathic-medicine.pdf).
3. Association of American Medical Colleges. Results of the 2014 Medical School Enrollment Survey (https://www.aamc.org/data).
4. General appropriations bill for the state of Texas, state fiscal years 2016-17. October 22, 2015:III-53 (http://www.lbb.state.tx.us/Documents/Budget/Session_Code_84/HB1-Conference_Committee_Report_84.pdf).
5. National Resident Matching Program. Advance data tables: 2015 main residency match (http://www.nrmp.org/wp-content/uploads/2015/03/ADT2015_final.pdf).

DOI: 10.1056/NEJMp1511707

A Never-Ending Battle

Vyjeyanthi S. Periyakoil, M.D.

"Were you in the Army, Navy, Air Force, Marine Corps, or the 'Guard'?" I asked as I admitted my patient, a 78-year-old veteran.

Mr. M. had florid heart failure, the result of multiple myocardial infarctions over years, each one taking a big bite out of his heart's pumping abilities and leaving his lungs and body waterlogged. His aging kidneys had slacked off, too, and despite maximal medical therapy he was now looking at a remaining lifespan of weeks. He was wheelchair-bound and tethered to his oxygen cylinder owing to profound air hunger.

He sketched me a mocking salute. "U.S. Army Cavalry Scout reporting for duty, Ma'am!"

"Have you seen combat?" I asked.

He idly gestured toward the