A Survey of State Financing of Psychiatry Residency Programs

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With upcoming cuts in graduate medical education funding, it is likely that many psychiatry residencies will be searching for new sources of revenue. State funding of residency programs is one possible avenue. The authors surveyed all Accreditation Council for Graduate Medical Education-accredited psychiatry residency programs to assess the present dimensions of state funding. Some programs in both publicly funded and private settings receive large proportions of their budgets from the state. Service commitments are common. State support of psychiatry residency education is currently an important source of funding and could become even more important in the near future. (Academic Psychiatry 1998; 22:155–161)

Funding for psychiatry residency training programs is provided largely by the federal government through the Medicare program’s graduate medical education (GME) pass-through mechanism (1). Hospitals receive their GME funds through two different mechanisms, each calculated in separate ways. The direct pass-through is calculated by adding the costs of house staff stipends, fringe benefits, some salaries for teaching faculty, office space, and a few other costs. The indirect pass-through amount is added onto the diagnosis-related group (DRG) fee for a particular hospitalization reimbursed by Medicare.

Several factors are likely to result in future decreases in these federal funding mechanisms for residency programs. These include federal budget-deficit pressures to reduce spending (2–4), diminished indirect GME funding resources (5), and selective GME funding for primary care residencies, resulting in a net decrease for all other specialties (5).

Given these circumstances, many programs will be looking for other funding sources. As recently as 1993, clinical income from faculty practice plans accounted for some 33% of the revenue of American medical schools (6). However, in cognitively based specialties such as psychiatry, patient care revenues are smaller than those of procedure-oriented specialty programs and are likely to be unable to provide much support for training programs (7,8). Training and research grants are a negligible financing resource.

State funding dollars are a current source of residency financing for some programs and a possible source for others. While limited state budgets make residency

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funding compete with many pressing social needs, states may have an interest in expanding the supply of psychiatrists for rural, chronically mentally ill populations, and other underserved areas. The Medical College of South Carolina’s residency program is one such example of successful state–residency partnering (9).

Overall, there is little comprehensive state funding information available with respect to psychiatry residency training. In cooperation with the National Association of State Mental Health Program Directors and the Research Institute, this survey sought to 1) understand recent and future trends in state funding of psychiatry residency programs, 2) detail how state monies are used in programs, and 3) clarify regional differences in state funding.

METHODS

A survey questionnaire consisting of eight items was developed by the authors and pretested in their home psychiatry department (Appendix 1). Programs were asked to identify and describe funding received from the state other than through the general university budget. The questionnaire was sent to each business manager or equivalent staff person in all psychiatry residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Programs were categorized as located in publicly funded or privately funded institutions on the basis of American Association of Medical Colleges’ (AAMC’s) data gathered from the 126 U.S. medical schools accredited by the Liaison Committee on Medical Education (LCME) and by directly contacting programs not affiliated with a medical school (6). Publicly funded institutions were those universities or medical schools receiving funding from their state for the university or medical school general fund. Privately funded institutions were those institutions not receiving state funding for the general fund. Programs were assigned to one of four geographic regions (10). Surveys were mailed to 200 programs. Responses were confidential and anonymous to all but the authors. Second and third mailings were sent to non-respondents, each sent 2 months after the last contact.

RESULTS

Questionnaires were returned from 130 of 194 programs (65% response rate). Ninety-six residencies were located in publicly funded institutions. Sixty-three of these schools responded (return rate 66%). Not all programs reported all data on the questionnaire.

The number and percentage of regional respondents were Northeast (n = 32, 49%), Midwest (n = 34, 83%), South (n = 45, 75%), and West (n = 19, 68%). Nationally, there was a 2:1 ratio of university vs. community respondents and a 1:1 ratio of public vs. nonpublic programs.

Data were then examined by region. With respect to university vs. community respondents, the Northeast had a 1:1 ratio, and Southern programs had a 3:1 ratio. No significant regional differences were noted with respect to public vs. nonpublic ratios or program size. Small numbers of respondents for each state made intrastate comparisons difficult.

Of all programs in publicly funded institutions responding, 39 programs reported a total residency budget averaging $1,235,378. The average amount received from the state was $598,875. Fifty-five percent of their residency budget was state supported. Among the programs located in private institutions reporting funding totals (n = 37), the total residency budget was $1,189,322. Fifteen (22%) of these programs reported that they received state funding. The average funded amount was $801,753.

Table 1 describes 1) the percentage of programs in publicly funded institutions reporting changes in state funding, 2) the per-