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Solutions to the Primary Care Physician Shortage

A primary care physician shortage currently exists in this country. As millions get health insurance under the Patient Protection and Affordable Care Act, this shortage is likely to grow. It is imperative that leaders recognize the need to grow primary care capacity. This piece will explore solutions to increase primary care capacity in the United States.

The Kaiser Family Foundation estimates that 8073 additional primary care physicians are required to eliminate Primary Care Health Professional Shortage Areas from the United States in 2014.[1] Petterson et al[2] forecast that the United States will require 52,000 more primary care doctors by 2025; the majority (33,000) will be needed because of population growth; aging and insurance expansion will require an additional 10,000 and 8000, respectively. These estimates are based on current practice patterns and do not consider that physician panel sizes may be smaller in the future, which would amplify the primary care physician shortage.[3] To compound matters further, primary care physicians now work part-time more frequently and are retiring at an earlier point in their careers than in the past.[4]

Solutions to increase the number of primary care physicians have been proposed. Increased emphasis on primary care by medical schools is a common starting point. This is being done through opening of new medical schools with novel curricula with earlier integration of clinical experiences. Another expanding source of primary care physicians is the rapid growth of osteopathic medical schools that stress primary care career paths. Existing allopathic schools are exposing medical students to primary care at an early stage. Beverly et al[5] found that a week-long primary care course favorably affects the perceptions of first year medical students toward the specialty. More research will be needed to determine whether this type of exposure influences selection of primary care career paths. Certainly these will help, but it is likely more will need to be done to solve the problem.

Although medical schools are increasing enrollments and new schools are opening, they are doing so in a setting of insufficient residency training positions. The Patient Protection and Affordable Care Act includes redistribution of unused residency positions to primary care programs and grants for new primary care programs. New legislation to both eliminate the 1997 Balanced Budget Act cap on graduate medical education spending and increase graduate medical education funding to increase the number of residency positions is badly needed. The bipartisan Resident Physician Shortage Reduction Act of 2013, which proposed 15,000 additional graduate medical education positions, but is yet to reach the floor of either chamber of Congress, could preferentially support primary care training programs.

At the same time, outpatient rotations in medical school and internal medicine residency must be strengthened. A task force of the Alliance for Academic Internal Medicine concluded that outpatient medicine "remains a lesser component of residency training than inpatient care, both in time and perceived importance."[6] Economic and political factors push the emphasis of postgraduate training to the inpatient setting. Because residents spend most of their time in the hospital, it is likely that many residents are imprinted to pursue inpatient and procedural careers. To encourage young doctors to choose primary care, the quantity and quality of the outpatient training experiences during residency should be enhanced. For example, the American Board of Internal Medicine could consider an alternate training pathway with an ambulatory predominance, much like family medicine programs where trainees spend most of their time in the outpatient setting. The Patient Protection and Affordable Care Act provides $230 million in fiscal years 2011 to 2015 to support community-based training programs through the Teaching Health Center Graduate Medical Education program. Also, it will be important to create ambulatory experiences where medical students and residents are not torn between inpatient rotations and their clinics and where they work with faculty who favorably perceive primary care and their careers.

Healthcare policymakers have a great opportunity to make primary care more attractive to internal medicine trainees, including enhancing income potential. The Patient Protection and Affordable Care Act offers some reimbursement improvements for primary care services (especially in rural settings) and loan repayment programs. Policymakers could consider further payment reform that shifts emphasis from procedural specialties to primary care.

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The work environment of primary care internists is shifting away from direct patient interactions to documentation and other responsibilities, such as calling patients, sending patients e-mails, talking with families, coordinating care, following up tests and imaging, refilling prescriptions, and speaking with consultants. Gilchrist et al[7] reported that primary care physicians spend 39% of their work day outside the examination room completing patient care—related tasks.[7] Farber et al[8] found that every 30 minutes of a patient's visit produces 6.7 minutes of additional work. It remains to be seen how the amount of non—face-to-face work will change under health care reform. Although by no means a silver bullet, it is possible that outcome-based payment reform models such as accountable care organizations, episode-based care, and bundled care models could influence this trend. For the present time in the current fee-for-service environment, nonpatient contact service should be remunerated. One approach would be to create Current Procedural Terminology codes for tasks such as e-mail and telephone encounters. Another would be to let physicians bill insurance companies for the time spent doing non—face-to-face work. A third possibility would be to find the average time that a doctor spends outside of the examination room per patient per month and assign this a per-patient monthly value. The latter would likely be the simplest to implement. A payment system that emphasizes more of the valuable contribution of primary care doctors would allow them more opportunity to listen, connect, and care for their patients. Such a system could also produce a more satisfying career that might attract more young doctors to the field.

Beyond attracting more young doctors to the discipline, another solution would be to improve the productivity of primary care providers. We envision 2 broad ways that instilling greater flexibility and deregulation can accomplish this goal. Currently, there are very rigid regulations as to what determines a medical visit and the required documentation. Doctors and patients would both be well served if doctors had greater leeway to define the medical visit and the documentation for that visit. Flexibility would let primary care doctors spend more time with patients, which could foster better care and enhance productivity, allowing them to see more patients in a day, thereby improving access, quality, and cost. It could also foster new mediums and models of care that could have a similar impact.

Another opportunity to increase the productivity would be a greater emphasis on team-based care. Many variations are possible, such as physicians working with 1 or more advanced practice providers, such as advanced practice nurses, physician assistants, nurse practitioners, pharmacists, behavioral health specialists, health educators, and care coordinators, who could provide evidence-based screening, counseling, and preventive care and logistic support, leaving physicians to manage diagnostic challenges and complex medical issues. Several areas where other staff members could help would be writing notes, refilling prescriptions, and managing tasks and patient flow. A greater emphasis on team-based care could leverage physician time and skills and magnify their impact on patient health.

Primary care physicians are integral to the health system and are necessary to meet the goal of improving patient health. As health care reform moves further forward, the need for a bigger, stronger, more functional primary care work force will become even more pronounced. We hope policymakers in Washington and leaders in academia will consider these recommendations to curb the effects of the primary care physician shortage.

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