



FAMILY PHYSICIAN WORKFORCE REFORM: Recommendations of the American Academy of Family Physicians

Mission

1. To speak with a unified and cohesive voice regarding the development of the family medicine workforce on state and national levels.

Objectives

2. Identify the appropriate proportion of the nation's physician workforce that should be family physicians to ensure efficient healthcare delivery with attention to access and value, effective healthcare addressing quality and cost, and equitable care with regard to disparities and distribution.
3. Review demographic changes in the U.S. population and adjust workforce projections accordingly.
4. Discuss the impact of increased healthcare coverage on family physician demand, utilization, and access.
5. Review demographic changes in the family physician workforce, such as physician disengagement from clinical practice, part-time practice, and clinical reentry.
6. Identify needed changes in healthcare financing and medical education funding to meet stated priorities.
7. Address the ongoing increase in medical school production (through the addition of new schools, addition of branch and regional campuses to existing schools, and increases in medical school class size) and graduate medical education funding policies, and their anticipated impact on family medicine workforce.
8. Review trends in general internal medicine, general pediatrics, nurse practitioner and physician assistant workforce and identify how those trends influence family physician workforce and distribution.
9. Provide data that will be accessible to state chapters, medical schools and other constituents.

Background

10. The current AAFP Policy "Family Physician Workforce Reform" as approved by the Congress of Delegates in September 2011 states that the AAFP should regularly assess and report on the family physician workforce. Accessing reliable health care is a major concern of the American public, and consistently ranks high on national surveys.¹

11. Updating AAFP Workforce Policy is not only timely but also necessary because of the national discussion about medical school social accountability, the misalignment of GME spending with the workforce needs of the country, health care delivery, physician practices, and patient access. Other important considerations include an increase in medically underserved populations, a new federal administration with an agenda to address health system reform and a new model of enhanced health care delivery. These changes require a workforce policy with greater specificity in its recommendations, and they present an opportunity to positively impact both national and state health policy. Addressing the national health workforce is a recognition of health care as a public good and that maintaining a sufficient number of well-trained and appropriately deployed family physicians is in the public's best interest.²⁻⁵

12. The Council of Academic Family Medicine (CAFM), comprised of the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, the North American Primary Care Research Group, and the Society of Teachers of Family Medicine, with contributions by the AAFP and the American Board of Family Medicine, created a position paper entitled "Four Pillars for Primary Care Physician Workforce Development" to serve as the foundation for family medicine workforce advocacy. The document recognizes that a successful workforce advocacy plan must address the physician pipeline, the process of medical education, practice transformation, and payment reform to promote, train, and sustain primary care physicians.⁶

13. Projecting the appropriate family medicine workforce composition and distribution must be part of any discussion of high-quality and efficient health care delivery; it also must be part of an agreement on the population health outcomes goals to be achieved. The AAFP has commissioned studies of the health workforce that have resulted in policy statements.^{7,8} The need to have a sound, data-driven workforce plan with clearly articulated policy recommendations is critical to advocacy initiatives during times of health system change.

Situation Analysis

14. The demand for primary care is expected to continue to increase at least through the year 2020 based largely upon the needs of a population that is both growing and aging as well as a modest increase associated with health insurance expansion as a result of the Affordable Care Act.⁹

15. There are approximately 275,000 primary care physicians currently in the United States. Of those, about 39 percent are family physicians.¹⁰ Adequate workforce projections are a key piece of the development of advocacy priorities if the AAFP is to meet its goal of ensuring access to care in a patient-centered medical home for everyone. Accurately projecting the health workforce is challenging, due to the complex nature of the many variables involved, the assumptions which underlie each variable, the methodology used, and the lack of a national workforce policy or model. For this reason, accurate health workforce projections remain elusive and controversial.

16. Recruitment, training, and retention constitute the longitudinal progression of the development of the family physician workforce. Differing factors influence each of these three components. Similarly, institutions with different missions influence various aspects of the overall physician workforce pipeline. Other variables

that influence workforce include workforce trends of other healthcare disciplines and socioeconomic trends that influence the public's ability to access healthcare resources.

17. The U.S. health care system is characterized by excessive cost and substandard population health outcomes. There are multiple calls for health system reform. One example is the 2012 Institute of Medicine report calling for an exploration of primary care and public health integration to improve the health of individuals, communities, and populations.¹¹ A condition for any meaningful reform is a clearly articulated health workforce policy.

18. One durable finding is that primary care is essential to any efficient health care system. In order for the United States to control costs, reduce health disparities and deliver high-quality care, the primary care workforce must be strengthened and deployed in a manner consistent with the health needs of the population. Health reform without systematically strengthening the primary care base is unlikely to succeed.¹²

19. This policy statement goes beyond projecting a specific number of physicians, but rather describes key issues of national workforce coordination, fiscal reform, and delivery systems that are essential to contain health care spending and improve health outcomes.

Discussion

20. In 1961, half of U.S. physicians were generalists, primarily general practitioners. Since then, the percentage has dramatically declined.¹³

21. The demographics of the U.S. population will continue to change. Along with an increase in the overall population, the number of older Americans will continue to increase as people live longer, and they will have more chronic diseases. Cultural and ethnic changes will continue as the population becomes increasingly diverse. The U.S. physician workforce must be prepared to care for a larger, increasingly diverse and older population with an increasing number of chronic medical conditions.

22. The health care systems of countries now dedicated to universal coverage for and access to health care are based on a foundation of generalist physicians, usually family physicians, at a higher proportion than is now present in the United States. These countries, as well as the more cost-efficient, closed-panel health maintenance organizations (HMOs) in the United States, tend to use fewer subspecialist physicians and a higher proportion of generalist physicians.¹⁴

23. The increasing generalist-specialist imbalance in the United States undermines the nation's ability to achieve universal health care access and limits its ability to meet needs of underserved populations. Primary care services provided by limited specialists and sub-specialists who have had little or no primary care training or continuing education can be expected to be both costly and inefficient, because limited specialists tend to use technologies and procedures of their specialties more than generalists. Furthermore, because of their narrower educational focus, limited specialists will more frequently seek consultation for patients who have common acute and chronic illnesses. Services may be fragmented and duplicated by visits to multiple specialists, and preventive services may not be provided adequately.¹⁵⁻¹⁷

24. Many nationally recognized groups, including the Council on Graduate Medical Education, the Association of American Medical Colleges, the Robert Wood Johnson Foundation and the Pew Health Professions Commission, have called for at least 40 percent of U.S. medical graduates to enter generalist careers.¹⁸⁻²⁴ In 2006, the AAFP completed a comprehensive workforce study that identified the ideal ratio of family physicians to population calculated from a needs-based model.⁷ However, many other factors, such as the demographic changes of the U.S. population, new models of healthcare, achieving recommended health screenings, aging physician demographics and practice patterns, and health reform measures that may include expanded insurance coverage will affect the workforce need.

25. As an example, in April 2006, Massachusetts passed a state bill designed to provide health coverage for its 600,000 uninsured. Despite being the state with the highest ratio of primary care physicians to population (125.6 physicians per 100,000), the act resulted in an immediate crisis of health care access.²² Significant delays in care have resulted with some patients waiting more than a year for a simple physical examination.²³

26. Recent projections from multiple workforce reports and publications predict major shortages in primary care providers, especially for the adult population. The American College of Physicians has expressed overt concern regarding the decline in the number of general internists.²⁴ In 2008, a study in JAMA revealed that only 2 percent of medical students planned to pursue general internal medicine careers.²⁵ The Association of American Medical Colleges (AAMC) reports an impending “crisis” in provider access, and even the organizations of non-physician providers are struggling with trends toward specialization and away from primary care.²⁶ Recent trends in graduate medical education show that the number of family medicine and general internal medicine residency positions and training programs have dropped at the same time that there was continued growth in subspecialty training and non-primary-care core specialties.²⁷ Even within the primary care specialties, there are significant differences between the specialty-to-population growth rates, with pediatric growth outpacing that of family medicine and internal medicine, despite a declining birth rate, which adds to the complexity of a primary care workforce projection.²⁸ With the declining numbers of other providers of primary care, the number of ACGME trained family physicians must be increased to meet the public’s needs.

27. The results of the 2006 AAFP Workforce Study found that, in order for all in America to achieve adequate access to a primary care physician, 139,531 family physicians will be needed by the year 2020. The results of the 2006 AAFP Workforce Study reported that the nation will need approximately 39,000 more family physicians by 2020 in order for all Americans to achieve access to a primary care physician. In 2008, Colwill and others predicted that population growth and aging will result in a deficit of up to 44,000 adult care generalist physicians by 2025.²⁹ Subsequent analysis and the more-rapid-than-expected decline in the production of general internists suggest that shortages of adult care generalists will be even worse than predicted, and that family physicians will be relied upon to close the bulk of that gap.³⁰

28. A determined number of training positions in U.S. health professions education outside of residency pathways to certification should be available annually for exchange visitors whose costs are paid by their home countries and who return to practice in their home countries upon graduation.

29. Both allopathic and osteopathic medical schools are rapidly increasing the pipeline of physicians both through expanding class sizes and opening new medical schools. Attention also must be paid to ensure that the increasing number of graduates will provide the kind of care most needed.

30. Federal funding for graduate medical education should reflect physician workforce policy, with preferential funding for training primary care physicians, particularly family physicians, and concomitantly less funding for the training of other physicians. All payers of health care services should contribute to paying the costs of medical education. A public-private entity should be established to allocate funding for residency positions among training programs based on the nation's workforce needs. Preferential funding should be given to residency programs that have a track record of producing generalist physicians, physicians located in and or serving rural and inner-city populations, or physicians from underrepresented minorities.^{18,32}

31. The physician workforce is dynamic and changes in physician work patterns can be anticipated. Increasing numbers of physicians choosing to leave practice, return to practice after periods of clinical inactivity, part-time practice, and other factors will affect the number of physician FTEs (full-time equivalents) providing patient care.³³

32. A critical issue central to the AAFP's current recommendations is the identification of the family physician as the provider of choice for primary care services for Americans, rather than abdicating the role of primary care provider to others, as it appears other adult specialties are doing. Given the extent and breadth of training, the quality outcomes and cost efficiency of practice, as well as the demands of delivery systems and satisfaction of patients, family physicians will be at a competitive advantage and will fill critical roles in the health care marketplace. Current recommendations are intended to support efforts to ensure health care access for all in America and to meet the needs of underserved rural and urban populations.

33. The delivery of emergency medical care in the US is an essential public service that requires a cooperative relationship among a variety of health care professionals. The Institute of Medicine Report on Emergency Care and others confirm the critical role of family physicians along with emergency medicine specialists in the emergency care workforce. The AAFP supports family physicians as essential and qualified providers of emergency care in a variety of settings, especially in rural and remote communities.

34. The number of students graduating from Nurse Practitioner (NP) and Physician Assistant (PA) programs continues to rise. However only approximately one half of NPs and one third of PAs are estimated to be practicing primary care.⁹ While PAs and NPs remain important contributors to the primary care workforce and are an important part of the team-based approach within the Patient-Centered Medical Home model of care, their contribution will be affected by the increase in the percentage of PAs and NPs who practice in subspecialty disciplines rather than primary care.³⁴

SUMMARY RECOMMENDATIONS

National Workforce Planning:

35. A national health workforce commission was established by the Affordable Care Act but never funded and therefore unable to meet as a commission. The need for a functioning national health workforce commission remains.³⁵ This body will represent the multiple stakeholders and report to Congress and the Executive Branch as appropriate. The charge of this commission will be to establish a national workforce database and to develop a strategic plan to align graduate medical education policy with the needs of the country.²⁶

36. There should be established a public-private entity to allocate funding for graduate medical education positions in accordance with the national health workforce commission priorities.

37. The AAFP should regularly assess and report on the family physician workforce, including attention to GME positions, the number of family physicians, their geographic distribution, demographic information (including racial and ethnic diversity), practice patterns, and market share.

Specialty Distribution of the Physician Workforce:

38. The evidence for the efficiency of health systems based on robust primary care is compelling. The percentage of U.S. primary care physicians is low and falling. A 10-year national plan should target at least 40 percent of the total number of U.S. physicians to practice in true primary care specialties (Family Medicine, General Pediatrics, and General Internal Medicine).¹⁸ True primary care practice should be measured by the clinical practice of family physicians, general internists, and general pediatricians five years after medical school completion.

39. To support efforts to ensure health care access for all Americans, the primary care workforce needs to grow from 209,000 to approximately 261,000.³⁶ Since family physicians currently make up about 38% of the primary care workforce³⁷, a conservative estimate is that an additional 21,000 family physicians are necessary to meet their share of the increased need. The annual production of new family physicians would have to increase by an average of about 65 each year, increasing from 3,500 today to 4,475 by 2025.³⁸

Funding/New Financial Models:

40. Funding for Title VII, Section 747 of the Public Health Service Act should be increased to support departments of family medicine. Medical schools that produce more primary care physicians should receive preferential funding.

41. The United States should increase payments to family physicians for clinical services in order to attract them to and sustain them in the new model of family medicine, and to promote improvement in health care delivery outcomes.

42. New physician payment models must be developed, tested, and implemented in order to remedy the unsustainable income gap between primary care physicians and other specialties. State and federal insurance programs should immediately undertake a series of demonstration projects in payment reform that

emphasize primary care, underserved and rural practices. Care coordination fees should be developed, tested, and implemented.

43. All payers of health care services should be contributing to the costs of medical education.

44. High-quality ambulatory practice will be a major pathway to reducing overall health care expenditures. Approximately two-thirds of family medicine training takes place outside of the hospital. Two-thirds of CMS Graduate Medical Education funding should track directly to residency programs to support training in the ambulatory setting.³⁹

45. Collaborative rural training sites should be prioritized under expanded Title VII funding. Physicians trained to provide care in collaborative clinical training practices that include nursing, mental health providers, social workers and pharmacists, among others, will result in improved multi-disciplinary team-based care that is essential to delivering high quality preventive and chronic care services. Rural sites have unique challenges to developing these models, and federal funding should assist with eliminating barriers to the development of collaborative, multidisciplinary training programs.

46. Training programs that produce physicians from underrepresented minorities, or those whose graduates practice in underserved rural or urban communities should be preferentially funded.

47. National funding for graduate medical education should reflect population health needs in the United States, preferentially funding training for needed generalist physicians, particularly family physicians, with concomitantly less funding for the training of other physicians. Specifically, additional training positions will need to be funded for family medicine rather than for other specialties.

Medical Schools:

48. Medical school expansion must be developed in ways that target primary care practice, including rural and underserved areas. Medical school expansion without realigning incentives will add more non-primary care physicians, largely in areas where they are not needed, thereby increasing cost to the health system without improvement in population health outcomes.

49. The AAMC has formed a “Group on Regional Medical Campuses” to address issues and assess impact on the expansion of medical schools through the development of branch and regional campuses. This group is collecting reports that validate the perspective that regional campuses produce more primary care physicians.⁴⁰⁻⁴²

50. As medical schools expand their class sizes, a portion of the new slots should be dedicated to students who plan to choose family medicine or other primary care careers.

51. Loan repayment programs for primary care careers should be significantly increased to eliminate medical school debt as a barrier to choice of careers in primary care.⁴³

52. Medical schools must be funded with appropriate incentives to address the public’s physician workforce needs. Financial incentives to medical schools that consistently produce higher numbers of primary care

physicians should be developed. Understanding the time it takes to adjust a teaching and training model, the incentives should be modified on a five-year needs-based model.

53. Medical schools should be encouraged to develop admissions policies that identify and recruit those students most likely to pursue careers in primary care.⁴³

54. Medical schools should develop programs that focus on the recruitment and training of underrepresented minority medical students. It is known that these students are more likely to provide a disproportionate share of health care to the growing minority and underserved populations in this country.²

55. All medical schools should manage their recruitment efforts to attract students most likely to select career paths and practice locations that will improve the current state of geographic, demographic, and specialty mal-distribution of both types and numbers of physicians across the nation.

56. All medical schools need to provide mentoring and role modeling to support medical students' access to family medicine experiences with competent and caring family physician role models and mentors. Schools must ensure that students have quality clinical experiences in preceptorships, clerkships, and electives that showcase the full scope of family medicine⁴⁴

Graduate Medical Education:

55. Graduate medical education represents the opportunity to prepare students who have selected the discipline of family medicine to deliver care that meets the needs of the communities that they will serve. The AAFP should continue its high level of support for graduate medical education in family medicine residency programs. Educational strategies should include:

- Enhancing the teaching skills of practicing physicians who work with family medicine residents and medical students, through the establishment of teaching skills' workshops and being supportive of efforts with similar goals sponsored by the other academic family medicine organizations.
- Continuing to support the activities of the *Residency Program Solutions*, which helps residency programs continually assess and improve the quality of their educational programs.
- Monitoring the practice locations and practice scope of graduates of family medicine residency programs to ensure that the public's needs continue to be met.
- Encouraging and recognizing innovation in training that ensures future family physicians will meet the needs of their patients in the context of their communities.

Delivery Systems:

58. The AAFP should continue development and implementation of the Patient-Centered Medical Home as defined by the Joint Principles of the Patient-Centered Medical Home.⁴⁵

59. Family medicine residencies should prepare family physicians for the evolving demography of the U.S. population, with special attention to using high functioning teams armed with data-driven quality improvement systems to provide continuity and access to care in order to manage the care of individuals and populations.⁴⁶ The Patient-Centered Medical Home model should be implemented in all family medicine residency programs.

Access:

60. Community Health Centers (CHCs) are a major delivery system in rural and underserved areas of the United States that have a significant problem with access to primary care services.⁴⁷ As the or previously uninsured are increasingly brought into the system, CHCs are likely to be critically important for health care access. If 30 million patients are to be served by 2015, 15,585 additional family physicians will be needed. If 69 million are to be served — as some have projected — an additional 51,299 primary care physicians will be needed.³⁰ CHCs should be increasingly utilized as teaching and training sites for physicians and funded to do so.²⁸

61. Strategies must be employed to improve access to health care for the 70.7 million designated as Medically Underserved Populations (MUP) and the 33.4 million people who live in geographic Health Professional Shortage Areas (HPSAs) ⁴⁸ Amelioration of HPSAs will require a comprehensive approach that includes training more family physicians in rural settings, expanding opportunities for students to trade medical school debt for service, expansion of the National Health Service Corps (NHSC), and improving physician payment for rural practice.

62. The AAFP supports policy that acknowledges the role of family physicians as providers of emergency medical care, especially in rural and other community hospital settings that depend upon family physicians as part of a comprehensive approach to addressing the nation's need for access to emergency care.

63. Physician compensation models for underserved practice locations (HPSAs, MUPs and Medically Underserved Areas) should be developed, tested, and implemented.

64. Primary care nurse practitioners and physician assistants should be practicing in integrated practices with primary care physician-led teams utilizing the Patient-Centered Medical Home model.⁴⁹

Community Health Centers:

65. In order to provide a pipeline of physicians for the nation's expanding CHC programs, the NHSC should be increased from 3 to 4 percent of physicians in the current program to provide opportunities for 6 to 12 percent of physicians.⁴⁷

66. Develop a Senior NHSC program. In addition to training new family physicians, retaining existing senior physicians and redeploying them to areas of need is an understudied strategy. This special program would retain experienced physicians who would otherwise retire, and employ them in areas of need.

67. Streamline the linkage of Graduate Medical Education (GME) funding to the development of "Educational Health Centers" in association with CHCs to ensure that higher proportions of family physicians complete training in rural and underserved sites. Family Medicine residents who train in CHCs are more likely to continue to care for underserved populations.³⁶ The Teaching Health Center Graduate Medical Education Program funded by the Affordable Care Act in 2010 is designed to support direct payment to ambulatory organizations that sponsor new or expanded primary care residency programs. This program is limited in scope and its funding is tied to the annual federal appropriations process after the first five years.⁵⁰

68. Continue support and expansion of 1-2 Rural Training Tracks (RTT) with federal funding of these programs currently through the RTT Technical Assistance Demonstration Project.⁵¹

Geriatrics:

69. Title VII funding should be expanded to encourage improved geriatrics training and care through support of Academic Departments of Geriatrics, geriatric fellowship programs, and incorporation of geriatric education throughout the training of all adult primary care providers.

70. New physician payment models for providing geriatric care under the Medicare program should be developed, tested, and implemented.

71. There should be an increased emphasis on the recruitment of a diverse student population reflecting those most likely to care for rural, underserved, and elderly populations, and who more closely resemble the racial and ethnic make-up of the U.S. population.

International Medical Graduates

72. International medical graduates will continue to be important contributors to the U.S. physician workforce. Care must be taken to avoid the recruitment of physicians from countries with shortages of health care providers and the creation of a “brain drain” that will worsen the health care needs of their home countries.⁵²

73. A determined number of training positions should be available for exchange visitors who plan to return to practice in their home countries upon graduation. The national health workforce commission should study and make recommendations on this issue.³⁵

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