Aligning Resources, Increasing Accountability, and Delivering a Primary Care Physician Workforce for America

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PRESENTED BY

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

INTRODUCTION

Our country faces an acknowledged physician workforce shortage. Factors contributing to our current workforce challenges are numerous and compounded by decades of neglect, misalignment of priorities and resources in medical education, and the inherent financial interest and competition between parties in the health care industry. In our history, we have never made an effort to establish a workforce policy that aligns human and financial resources with desired goals. Instead, we have relied on local and community economic forces to make these decisions on our behalf.

While our current system excels at educating and training highly trained specialists and physician researchers, it is failing to produce the number of primary care physicians our citizens need and expect. As a result, despite spending approximately $15 billion annually on graduate medical education, the United States will require almost 52,000 additional primary care physicians by 2025. Our current shortage is driven by several factors, but there are three major reasons we need more primary care physicians:

- An increase in the number of people who have health insurance
- Growth in our population
- Aging of our population

"Primary care is first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system." The impact of primary care is well documented in academic research. Countries with stronger primary care systems are associated with improved population health care, including reductions in all-cause mortality, all-cause premature mortality, and cause-specific mortality from a number of acute and chronic conditions. Primary care is associated with better health outcomes through improved effectiveness and efficiency of care, with improved equity.

ABOUT THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians (AAFP) is the national association of family physicians. It is one of the nation's largest medical organizations, with more than 115,900 members in 50 states, Washington DC, Puerto Rico, the Virgin Islands, Guam, and around the world.

The AAFP was founded in 1947 to promote and maintain high-quality standards for family doctors who provide continuing comprehensive health care to the public. Until October 3, 1971, the AAFP was known as the American Academy of General Practice. The name was changed in order to reflect more accurately the changing nature of primary health care.

The AAFP was instrumental in the creation of the Four Pillars for Primary Care Physician Workforce Development. These pillars represent the essential areas of focus for policy makers and educators that, when acted on collectively, will increase the quantity and quality of the primary care workforce. The Four Pillars are:

- Pipeline
- Process of Medical Education
- Practice Transformation
- Payment Reform

The AAFP has developed a series of policy recommendations based on these four pillars, which will allow our country to increase the number of primary care physicians for the short and long term. It implements social accountability within the graduate medical education (GME) system to ensure that we are training the next generation of physicians who are prepared to meet the health care needs of all citizens. It proposes significant changes in the financing of GME that would allow for the use of acute and ambulatory settings to provide training opportunities for primary care and other physician specialties. Finally, our proposal seeks to align our nation's substantial financial investment with physician training that meets the needs of our population through a more robust primary care physician workforce.

WHAT IS PRIMARY CARE?

In 1996, the Institute of Medicine Committee on the Future of Primary Care recommended the following definition for adoption:

"Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

This is the most commonly cited definition of primary care in use today. It is articulated in terms of the function of primary care, not by who provides it, but by what it entails. There are six critical components of this definition:

1. Integrated and accessible services
2. Services that are provided by primary care clinicians, but that also involve other members of the patient-care team

3. Accountability of providers and the system for quality of care, patient satisfaction, efficient use of resources, and ethical application
4. The majority of health care needs for a patient, including physical, mental, emotional, and social components
5. A sustained partnership between patient and primary care provider
6. Care provided in the context of family and community

WHAT IS FAMILY MEDICINE?

Family medicine is the only physician specialty solely focused on providing primary medical care. Family medicine ensures continuous, comprehensive health care for the individual and family. It integrates the biological, clinical, and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system, and every disease entity. Family medicine is a three-dimensional specialty, incorporating (1) knowledge, (2) skill, and (3) process. Although knowledge and skill may be shared with other specialties, the family medicine process is unique. At the center of this process is the patient-physician relationship, with the patient viewed in the context of the family and community. It is the extent to which this relationship is valued, developed, nurtured, and maintained that distinguishes family medicine from all other specialties.

Family medicine's cornerstone is an ongoing, personal, patient-physician relationship focused on integrated care. There are family physicians in more than 95% of U.S. counties, and approximately one in four of all office visits are made to family physicians. That is 214 million office visits each year—nearly 74 million more than the next largest medical specialty. Additionally, family physicians provide more care for America's underserved and rural populations than any other medical specialty.

WHAT IS THE DIFFERENCE BETWEEN PRIMARY CARE AND PRIMARY CARE SERVICES?

It is important to distinguish between the delivery of primary care services and the delivery of continuous and comprehensive primary care. While numerous physician specialties may deliver certain primary care services to their patients, they do not provide the comprehensive primary care associated with care provided by a family physician, general internist, or general pediatrician. They do not do this because they are not trained to do so. This is a critical distinction. Primary care is first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by sex, disease, or organ system. It is provided by physicians specifically trained for and skilled in comprehensive, first-contact and continuing care for individuals with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care is largely provided by physicians who specialize in family medicine, general internal medicine, and pediatrics. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician who often collaborates with other health professionals and utilizes consultation or referral as appropriate. Primary care physicians provide patient advocacy in the health care system to accomplish cost-effective care by the integration of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

Other physician specialties routinely provide some primary care services to their patients, but these services are limited in both scope and frequency, and they fall short of the continuous and comprehensive threshold. Additionally, many nonphysician providers, especially nurse practitioners (NPs) and physician assistants (PAs), provide a significant level of primary care services. The services provided by NPs and PAs are important to the establishment of a primary care foundation in our nation's health care system, and each of these professions is an important contributor to the primary care team.

IS THERE A PRIMARY CARE PHYSICIAN SHORTAGE?

Various studies and projections show a current and predicted worsening primary care physician shortage. With nearly 209,000 primary care physicians in 2010, the United States will require almost 52,000 additional primary care physicians by 2025—approximately 33,000 to meet population growth; approximately 10,000 to meet population aging; and approximately 8,000 to meet insurance expansion.

The United States not only faces a shortage but also a maldistribution of primary care physicians. This deficit is of particular concern given that access to health insurance is slated to increase substantially, the elderly population continues to grow, and many rural, poor, and minority communities remain medically underserved. However, fewer medical school graduates are choosing primary care as a specialty today than in the past.

According to the Health Resources and Services Administration, the federal agency charged with improving access to health care, nearly 20% of Americans live in areas that have an insufficient number of primary care physicians.

HOW AND WHERE ARE FAMILY PHYSICIANS TRAINED?

Family medicine residency programs are at least three years in duration, as are internal medicine and pediatric residencies. Successful completion of training is an eligibility requirement for the certification examination of the American Board of Family Medicine or the American Board of Osteopathic Family Physicians. Also available are a small number of four-year family medicine residency programs that participate in a pilot program sponsored by the Accreditation Council for Graduate Medical Education Residency Review Committee for Family Medicine and designed to provide ongoing data about the duration of training and outcomes of graduates. The program runs through 2020.

Training in family medicine is designed to achieve the expertise inherent in the principles of family medicine—care that is first contact, continuous over time, comprehensive in nature, and integrated with other parts of the health system. As a result, family medicine residents are trained in all patient-care settings. Approximately two-thirds of family physicians are trained in community-based residency programs—community hospitals (including intensive care, surgical care, and maternity care), community health centers (including federally qualified health centers [FQHCs] and FQHC "look-alikes"), and training programs supported by the Teaching Health Center Graduate Medical Education (THCGME) program. Training also occurs in outpatient physician offices, patients' homes, and long-term and hospice care settings. Residency training programs must have a sponsoring institution. In most cases, the sponsoring institution is a hospital.

DO FAMILY PHYSICIANS PROVIDE SERVICES BESIDES PRIMARY CARE?

At their core, family physicians are generalists. Their broad scope of training gives them the flexibility to adapt to the needs of the communities they serve, whether those communities are urban, suburban, or rural.

Some family physicians develop areas of concentration in their practices based on their passions and educational focus during or following their residency training. Examples of areas of focus include care of women and infants, care of adolescents, sports medicine, geriatrics, hospice and palliative care, care of patients who have HIV, hospital medicine, emergency medicine, urgent care, and global health.

Only approximately 15% of family physicians pursue fellowships or additional training. [AAFP Reprint No. 155-LL] Accredited and non-accredited fellowships include sports medicine, geriatrics, palliative care, obstetrics/women's health, hospital medicine, and rural medicine. In addition, faculty development and clinical research fellowships are available to provide focused training for family physicians interested in a more academic career path. Even among those who may have completed a fellowship or who have attained areas of concentration in their training, the majority of their practice remains primary care.

WHAT IS GRADUATE MEDICAL EDUCATION?

Graduate medical education (GME) is the training that medical school graduates receive as residents in more than 1,000 of the nation's hospitals. These are called "teaching hospitals," and they vary in size and specialty focus. GME includes internships, residency, and subspecialty and fellowship programs, and it leads to state licensure and board certification.

In order to compensate for that enhanced quality, Medicare pays a teaching hospital a portion of the direct graduate medical education (DGME) costs and indirect graduate medical education (IME) costs for the medical residents for which it is responsible.

HOW IS GRADUATE MEDICAL EDUCATION FINANCED?

The establishment and financing of a physician training system originated as a means of ensuring a robust and well-trained physician workforce while also providing much-needed health care services to patients, specifically those who faced financial hardship. When Congress established Medicare in 1965, it recognized that:

> *Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.*

In order to compensate for that enhanced quality, Medicare pays a teaching hospital a portion of the DGME costs and IME costs for the medical residents for which it is responsible.

While few "communities" have found other means to "bear such education costs," there have been numerous efforts to reform how the government pays for the training of physicians. In recent years, there has been a growing consensus that recipients of federal financial contributions to GME should be held accountable in some manner to their communities and states.

Support for GME comes from a number of public and private sources, but the federal government, through the Medicare Trust Fund, is the largest single financer of GME, contributing approximately $9.7 billion in Medicare funds and approximately $3.9 billion in Medicaid dollars to finance the nation's GME system. The federal government funds GME in children's hospitals through the Children's Hospitals Graduate Medical Education Payment Program and through community-based programs called Teaching Health Centers, which train residents in community-based ambulatory settings. The federal government also finances GME through the Department of Defense and the Department of Veterans Affairs. In addition to the federal government, many states finance GME through their Medicaid programs. In 2009, states contributed $3.78 billion to the financing of GME.[11]

HOW DOES MEDICARE CURRENTLY FINANCE GRADUATE MEDICAL EDUCATION?

Medicare supports GME through two separate methodologies: DGME and IME payments. DGME payments are designed to compensate teaching hospitals for "Medicare's share" of the costs directly related to the training of residents. The added direct costs of GME incurred by teaching hospitals include stipends and fringe benefits for residents; salaries and fringe benefits for faculty who supervise the residents; other direct costs; and allocated institutional overhead costs, such as maintenance and electricity. Other direct costs include the cost of clerical personnel who work exclusively in the GME administrative office.

Indirect payments are designed to subsidize hospitals for expenses associated with training resident physicians, such as higher utilization of services and longer inpatient stays. These payments are based in part on the number of Medicare patients seen by the hospital, the total number of resident physicians a hospital trains, and the number of Medicare patients it treats. Of the estimated $9.7 billion in Medicare funds spent on GME in 2012, approximately $2.8 billion went to direct payments and $6.8 billion went to indirect payments.[11]

HOW CAN GRADUATE MEDICAL EDUCATION FINANCING BE ALIGNED WITH THE HEALTH CARE NEEDS OF THE POPULATION?

The AAFP believes that the current and projected shortage of primary care physicians should be a national priority. The current GME system, through its financing and hospital-based structure, may actually work against achieving a physician workforce that meets the health care needs of current and future generations. Specifically, there is a distinct disconnect between the current allocations of taxpayer dollars to the actual health care needs of our citizens.

The AAFP proposes that federal and state funding should be accompanied by performance standards that require training in identified, high-need specialties such as family medicine. We also call for decoupling the financing from the hospitals' finances to better balance the workforce needs of the country against the financial needs of the hospital.

Our nation must meet the health care demands of a growing and aging population. In order to do this, we may require more graduate medical education positions. The AAFP recommends that any expansion in the overall GME supply be closely aligned to meet the health care needs of our nation—not simply be an expansion of our current system. Although our current system excels at preparing highly trained specialists and physician researchers, it is failing to produce the number of primary care physicians our citizens need and expect. The AAFP calls for greater social accountability in our GME system, just as numerous policy organizations such as MedPAC and other workforce experts have recommended.

The AAFP has developed a set of policy proposals that will allow our country to increase the number of primary care physicians for the short and long term. The AAFP proposal recommends social accountability within the GME system to ensure that we are training the next generation of physicians who are prepared to meet the health care needs of all citizens. The AAFP proposes significant changes in the financing of GME to align taxpayer dollars with the training of primary care physicians. Furthermore, the proposal makes recommendations for how we can use both acute and ambulatory settings to provide training opportunities for primary care and other physicians.

The AAFP anticipates a built-in resistance to many of the changes we have proposed. Our current GME system has become an enabler of our nation's high-cost health care system, a system that places greater emphasis on fragmented care versus the documented benefits of continuous and comprehensive primary care. However, the AAFP believes that our nation has an obligation to use its limited resources to meet the health care needs of the citizens whose taxes finance our GME system.

AAFP'S PROPOSAL TO REFORM GRADUATE MEDICAL EDUCATION

1. Limit payments for direct graduate medical education and indirect medical education (IME) to training for first-certificate residency programs.
2. Establish primary care thresholds and maintenance of effort requirements applicable to all sponsoring institutions and teaching hospitals currently receiving Medicare and/or Medicaid GME financing.
3. Require all sponsoring institutions and teaching hospitals seeking new Medicare- and Medicaid-financed GME positions to meet primary care training thresholds as a condition of expansion.
4. Align financial resources with population health care needs through a reduction in IME payments and allocation of those resources to support innovation in GME.
5. Fund the National Health Care Workforce Commission.

RESOURCES

- American Academy of Family Physicians (AAFP) Official Policies
- Council on Graduate Medical Education Twenty-First Report – Improving Value in Graduate Medical Education
- Council on Graduate Medical Education Twentieth Report – Advancing Primary Care
- Report to the Congress: Medicare Payment Policy March 2001 – Chapter 10
- Report to the Congress: Aligning Incentives in Medicare June 2010 Report to Congress – Chapter 4
- "First Teach No Harm," *Washington Monthly* July/August 2013
- Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey, Association of American Medical Colleges, Tim N. Henderson, April 2010
- Assessing the Impact of Potential Cuts in Medicare Doctor-Training Subsidies – Bloomberg Government Study, Brian Rye, February 28, 2012
- Robert Graham Center
- Health Resources and Services Administration
- Teaching Health Center Graduate Medical Education Program, Health Resources and Services Administration

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7 American Academy of Family Physicians Membership Survey 2014

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9 Shipman SA, Jones KC, Erikson CE, et al. Exploring the workforce implications of a decade of medical school expansion: variations in medical school growth and changes in student characteristics and career plans. *Acad Med;*88(12):1904-1912.

10 *House Report, Number 213, 89th Congress, 1st session 32 (1965) and Senate Report, Number 404 Pt. 1 89th Congress 1 Session 36 (1965).*

11 Institute of Medicine. Graduate Medical Education That Meets the Nation's Health Care Needs. July 29, 2014.