The US Primary Care Workforce and Graduate Medical Education Policy

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THERE IS A SHORTAGE OF PRIMARY CARE SERVICES IN the United States due to increasing demand and declining supply.[1] In 2010, in its 20th Report to Congress, the Council on Graduate Medical Education called for increasing the percentage of primary care physicians from 32% to at least 40% to address this shortage.[2] Although the Affordable Care Act (ACA) contains several important provisions to expand the primary care workforce, the effect of these policies is likely to be modest and their implementation likely limited if Congress does not appropriate the authorized funds.

Successful completion of an accredited residency training program is the path to medical licensure for most US physicians. Thus, graduate medical education (GME) is the spigot controlling the output of the physician workforce pipeline. In 2012, of the 22 934 US and international medical school graduates,10 624 (46%) matched into the 3 generalist residency programs of internal medicine, pediatrics, and family medicine.[3]

In this issue of *JAMA*, West and Dupras[4] studied 57 087 US internal medicine residents and found that only 21.5% of third-year internal medicine residents planned to practice primary care after completing training. In similar surveys of third-year residents, 45% of pediatric residents[5] and 90% of family medicine residents planned to practice primary care (Pugno P, vice president for education, American Academy of Family Physicians, Report on Survey of 2011 Graduating Family Medicine Residents, personal communication, November 11, 2012). Thus, of the 10 624 students matching into generalist residency programs, only 4648 (44%) plan to practice primary care after training. This means that only 20% of all 22 934 medical school graduates from 2012 will be expected to practice primary care in 2015. Even if half of all internal medicine residents chose primary care, the proportion of all graduates practicing primary care would increase, but only from 20% to 27%, still far short of the 40% rate recommended by the Council on Graduate Medical Education. Thus, the United States needs to consider changes in GME policy that better align the taxpayers' investment in physician training with the health care workforce that society needs.

In the study by West and Dupras,[4] 9.3% of senior residents planned careers in hospital medicine, removing these general internists from the office practice of primary care. Hospitalists have made valuable contributions to quality and efficiency in the care of hospitalized patients, but this growing field has further diminished the primary care workforce.[6] This "speciation" of general internists into office and hospital-based physicians may also be contributing to the primary care access problem.

Medicare is the major public source of GME funding and the principal driver of GME policy. The Centers for Medicare & Medicaid Services (CMS) currently contributes $9.5 billion annually to support the training of 110 000 residents at 1100 teaching hospitals.[7] Of the CMS payments, $3 billion is direct (salaries for residents, faculty, and staff) and $6.5 billion is indirect (added to Medicare diagnosis related group payments for the additional cost of care in teaching hospitals). The Balanced Budget Act capped the total number of Medicare-reimbursed GME positions at the 1996 level (approximately 98 000).[8]

The Medicare Payment Advisory Commission (MedPAC), a nonpartisan, independent board, has concluded that indirect medical education payments are $3.5 billion more than the amount empirically justified by comparing clinical costs among teaching and nonteaching hospitals.[9] In 2010, MedPAC recommended that CMS withhold this $3.5 billion and establish a pay-for-performance program with this balance according to standards and metrics designed to enhance the transparency and accountability of GME programs.

In contrast, the Simpson-Bowles Commission recommended that Congress use this empirically unjustified portion of GME funding to pay down the federal budget deficit.[10] President Obama's recent budgets adapted this strategy but Congress has not yet acted on these proposals.

Countering these threatened reductions in GME funding, the Association of American Medical Colleges has argued that the United States will experience a shortage of

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91 500 physicians by 2020 and has urged Congress to lift the cap to increase federally funded GME positions by 15% over the next few years.[11] However, Congress has shown little support for the cost of GME expansion given the current political climate of increasing budget deficits, and the ongoing debate about the appropriate size and role of the federal government.

Congress has the impetus for substantial GME reform, stimulated by the impending primary care shortage, the pressure to expand GME positions to address the shortage, and the recognition that GME funding must be made more transparent and accountable to society's needs, combined with the mounting fiscal and political pressures to reduce GME funding. Several bills have been introduced to address this issue but none seem likely to move out of Committee except in the context of larger fiscal reform.[12-14]

Despite these pressures, the path forward remains controversial as Congress hears conflicting claims and predictions about the physician workforce. Estimates of the needed size and distribution of the health care workforce are moving targets as the practice and payment reform provisions of the ACA are implemented and the role of nonphysician professionals increases. Congress needs an unbiased, nonpartisan, national consensus on workforce needs and GME policy. The ACA established a new board to provide just that, the National Healthcare Workforce Commission, but Congress has not appropriated the funds to permit the Commission to begin its work. In response to a request from a bipartisan group of US senators, the Institute of Medicine has initiated a study of GME policy and is expected to report its findings in early 2014.[15]

The United States has the opportunity to improve how the health care workforce is trained and to align GME funding with society's evolving health care needs. Policy makers will need ongoing intelligence from physicians, the Institute of Medicine, and the National Healthcare Workforce Commission to navigate a path through this complex problem.

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