Addressing the Primary Care Workforce Crisis

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ABSTRACT

Our nation's primary care system is in crisis. As medical homes and accountable care organizations increasingly rely on a strong primary care workforce, the shortage of primary care physicians now calls for more policy attention and urgency. In the spirit of the 2014 Institute of Medicine recommendations on graduate medical education (GME) funding, we propose that CMS explicitly reward teaching hospitals if a certain share of their graduates (we propose 30%) remain in primary care 3 years after residency, either through additional payments or release of a withhold. Such a policy could allow hospitals to retain GME funding at a time when continued federal subsidization of GME is being called into question. Moreover, hospitals stand to benefit from producing primary care physicians, both under traditional fee-for-service contracts that reward volume through referrals and, especially, under risk contracts that reward for greater numbers of covered lives.

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Our nation's primary care system is in crisis. As insurance coverage expands across the country, the foundation of our healthcare system—a strong and accessible base of primary care providers—is being stretched dangerously thin. This watershed moment compels us to rethink the fundamental workforce imbalance that has developed over decades. Whether measured by the millions who lack adequate access to primary care or an aging population that will increasingly rely on primary care, the magnitude of our primary care workforce shortage now calls for more attention and urgency.

The shortage of primary care physicians has many explanations,[1] with lower salaries relative to other specialties, paperwork burdens, and lifestyle differences coupled with a lack of prestige often cited.[2,3] Although recent discourse has centered on nurses and other providers filling this physician void,[4] the debate has largely ignored the future of physician training itself. Delivery system reforms such as medical homes and accountable care organizations rest on the premise that a generation of dedicated, value-conscious primary care physicians will exist to lead clinical teams, which will serve as the backbone of these innovations. Yet without parallel reforms in physician training, this human capital will likely not be realized.

How could policy makers help strengthen our primary care workforce? We offer a potential solution centered on reforming public funding for physician training.

Of the $15 billion in public funding for graduate medical education (GME) in 2012, $9.7 billion came from the Medicare program and another $3.9 billion came from Medicaid. Given this sizable public investment, CMS is uniquely positioned to influence the distribution of the physician workforce. Additionally, as the dominant insurer and chief architect of the physician payment system, CMS could create incentives for primary care training that align closely with its current efforts to more broadly improve the value of care.

Take-Away Points

Our nation's primary care system is in crisis. As medical homes and accountable care organizations rely increasingly on a strong primary care workforce, the shortage of primary care physicians now calls for more policy attention. We propose that policy makers explicitly reward teaching hospitals for producing primary care physicians. In the spirit of the 2014 Institute of Medicine recommendations, we propose a policy that could help grow the primary care physician workforce and also allow hospitals to retain graduate medical education funding at a time when continued federal support for this type of funding is being called into question.

Recently, the Institute of Medicine (IOM) convened a special committee to examine the role of the government and CMS in GME funding. In its report, *Graduate Medical Education That Meets the Nation's Health Needs*, the committee recommended the establishment of a unified policy-making body and operational body for GME funding decisions in the HHS, coalescing direct and indirect GME into a single fund with 2 subsidiary funds: one dedicated to the ongoing support for residency programs and the other to the testing of alternative GME payments, including performance-based payments.[5]

Although these recommendations are a meaningful step forward, implementation may take years given the nature of the legislative process. In the meantime, other policies that resonate with these recommendations may be required to meet the urgency of the primary care workforce needs.

We propose that CMS begin explicitly rewarding hospitals for producing primary care physicians. Today, only 21.5% of senior internal medicine residents intend to practice general internal medicine, and 39.6% of graduates in primary care tracks of internal medicine programs intend to stay in general medicine.[1] By raising medical education payments per trainee or as a proportion of the hospital's residency program, CMS can encourage these medical centers to inspire, mentor, and incent their trainees to consider careers in primary care. Such funds could be used to enhance primary care education programs for residents, financially support faculty in general medicine to focus on mentorship and apprenticeship of trainees, or pay for practice redesign in the resident clinics that helps ease the challenges of delivering primary care.

This solution—consistent with the IOM special committee's vision—could take the form of either carrots or sticks directed toward hospitals with training programs. We propose that hospitals receiving such funds would be measured on the percentage of graduates who remain in primary care practice 3 years following graduation from residency. If more than 30% of graduates should remain in the field, a hospital's medical education allotment would be augmented by a percentage that increases with the share of graduates in primary care. The increase could be linear, or it could be steeper at higher shares of primary care graduates to increase the hospital's reward at the margin. A 3-year window is appropriate for such an incentive as it accounts for the fact that many residents choose short-term positions to pay off educational loans before entering a penultimate position or fellowship.

In an alternative version of the policy, CMS could penalize hospitals for not producing a sufficient number of primary care graduates. Without infringing on the freedom of each trainee to choose his or her career path, CMS could design a payment withhold system. Mirroring the positive incentive approach, should less than 30% of total supported residents remain in primary care, a certain percentage of a hospital's GME funds could be withheld. This withhold could be larger or smaller based on the share of graduates entering into in primary care. Withheld funds could be redirected to support related federal or private efforts to increase the production of primary care physicians; they could also be redirected to CMS to fund pilots as suggested by the IOM Committee.

In the context of the big picture, this type of federal program could be one way for teaching hospitals to retain support for GME at a time when continued federal support of GME is being called into question.[6] Our proposal builds on the vision of the IOM Committee and is consistent with its philosophy that GME funds should be strategically invested to produce a physician workforce that can provide higher-value care for individuals and serve as leaders in the reform of our delivery system for populations.

Why should policy focus on the hospital? One reason is that the nexus of accountability rests with the hospital. Medical schools, clinical departments, or particular faculty members are not fiscally accountable for physician training, but hospitals are.[7]

Second, much of the work environment that serves to train new physicians is managed and controlled by teaching hospitals. The physical space, clinical rotations, support staff, and organizational structure in which physicians train are directly under the purview of the hospital. If structural changes are needed in primary care training, the hospital offers the most pragmatic lever to implement such change. While some career decisions are surely made before residency, ensuring a robust and attractive primary care training experience within a curriculum that recognizes the value of population health are critical domains that fall under the purview of residency.

Third, hospitals have much to gain from increasing their primary care workforce. Expanding access to newly insured patients not only aligns with their mission to serve the community and improves their standing locally or regionally, but it also boosts hospital revenues—both under fee-for-service contracts that reward volume gained through referrals from primary care and under risk contracts that reward increased numbers of covered lives. This contrasts with expanding more expensive service lines, which are profitable under fee-for-service, but potentially costly under risk contracts.

The aging of the population and the growth of chronic disease are agnostic to the primary care shortage, as well as to the stakeholders in today's policy debates. As the tectonic plates of demography and disease continue to strain an already overstretched primary care system, we believe the time for growing the primary care workforce is now.

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REFERENCES

1. West CP, Dupras DM. General medicine vs subspecialty career plans among internal medicine residents. *JAMA*. 2012;308(21):2241-2247.
2. Warm EJ, Goetz C. Too smart for primary care? *Ann Intern Med*. 2013;159(10):709-710.
3. Kussmaul WG 3rd. Too lazy for primary care? *Ann Intern Med*. 2013;159(10):711-712.
4. Chen PG, Mehrotra A, Auerbach DI. Do we really need more physicians? responses to predicted primary care physician shortages. *Med Care*. 2014;52(2):95-96.
5. Institute of Medicine. Graduate medical education that meets the nation's health needs. Washington, DC: National Academies Press; 2014.
6. Chandra A, Khullar D, Wilensky GR. The economics of graduate medical education. *N Engl J Med*. 2014;370:2357-2360.
7. Grover A, Slavin PL, Willson P. The economics of academic medical centers. *N Engl J Med*. 2014;370:2360-2362. ■

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