AAMC

Tomorrow's Doctors, Tomorrow's Cures®

AAMC Physician Workforce Policy Recommendations

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Association of
American Medical Colleges

Background

An adequate supply of well-educated, culturally competent, and highly trained physicians is essential in achieving equitable access to quality health care services for all Americans. The June 2012 Supreme Court decision to uphold the Affordable Care Act (ACA) has significant implications for the physician workforce as an estimated 32 million Americans may become newly insured under the ACA. Additionally, 10,000 Americans turn 65 daily and will continue to do so for the next two decades. As these individuals gain coverage through private insurance and Medicare, the United States is projected to confront a shortage of 91,500 doctors by 2020 (**Figure 1**). Underserved populations likely will continue to bear the greatest burden of the workforce shortage but extensive shortages across a number of specialties are likely to impede access to care for many Americans unless Congress acts immediately.

In 2006, the Association of American Medical Colleges (AAMC) issued a Statement on the Physician Workforce that included a recommendation to expand U.S. medical school enrollment by 30 percent over 2002 levels. Medical schools are on track to meet that 30 percent goal by 2016 (**Figure 2**) but residency training (or graduate medical education, GME) positions have increased only by 8 percent since 2002. The expansion of medical schools is an imperative step toward creating an adequate supply of physicians, but the limited availability of residency positions means that new physicians may not be able to secure residency training, a prerequisite for independent practice.

Physician training is inextricable from patient care and Medicare has historically paid for its share of the costs of training and the highly sophisticated health services provided by teaching hospitals. The Balanced Budget Act of 1997 capped Medicare-funded GME at 1996 levels for almost all teaching hospitals and continues to limit teaching hospital efforts to expand or create new programs. The ACA did not eliminate the cap but allowed for the training of approximately 300 additional physicians a year—far fewer than the 10,000 additional physicians the nation would need to train annually to address the entire physician shortage. Unless Congress increases the 1997 cap on the number of residency positions for which Medicare pays its share of the costs, the number of physicians per capita will decrease.

The caps on physician training were imposed at a time when most researchers predicted that the delivery system would rapidly and drastically change under the influence of tightly managed care. Today, the health care delivery system is in a time of significant transformation with numerous federal, state, and private efforts under way to improve coordination and quality of care, increase access, and reduce cost—many of which will likely have a significant impact on demand for physician services. It is too early to know the short- or long-term effect these nascent efforts will have on our future workforce needs, but these changes will take years to come to fruition. In the interim, it would be irresponsible for policy makers to ignore the nation's expanding health care needs. As demonstrated in Massachusetts, expanding insurance coverage leads to an initial increase in utilization of both primary and subspecialty care.

Despite the best-implemented health care delivery reforms, the growing and aging nation will need a larger physician workforce. The United States cannot afford to wait until the physician shortage takes full effect because by then, it will be too late. We must be proactive and remember that the education and training of a physician takes more than a decade. These recommendations are intended to ensure that policy makers understand that an adequate supply of physicians must be achieved both through more efficient health care delivery models and by increasing physician training positions. No single approach is sufficient; all of the following are necessary to ensure an adequate supply of physicians.

Policy Recommendations

1. **The number of federally supported GME training positions should be increased by at least 4,000 new positions a year to meet the needs of a growing, aging population and to accommodate the additional graduates from accredited medical schools. The medical education community will be accountable and transparent throughout the expansion.**

   Training an additional 4,000 physicians a year would allow the nation to increase its expected supply of doctors by approximately 30,000 by the end of the decade—meeting approximately one-third of the expected shortage. This represents an expansion of approximately 15 percent over current training levels, which would provide a sufficient number of positions to accommodate U.S.-educated doctors while allowing for international medical graduates (IMGs) to occupy about 10 percent of training positions. Absent the necessary increases in residency positions, per capita numbers of physicians will continue to fall as the population grows and ages with rising per capita needs.

   The AAMC believes that primary care is the foundation of a high-performing health system but it is equally important to increase the supply of subspecialists in many areas. As patients age, incidence of both chronic and acute conditions rises dramatically; U.S. health care has made great advances in the care of these conditions. Cancer, arthritis, diabetes, and other illnesses of adults will continue to be treatable disorders that require the care of oncologists, surgeons, endocrinologists, and other specialties. Children who previously would have succumbed to their illnesses will survive into adulthood but require decades of follow-up by primary care, pediatric subspecialists, and adult subspecialists. Meeting these needs cannot be accomplished without increasing the number of residency positions.

2. **Current and future targeting of funding for new residency positions should be planned with clear attention to population growth, regional and state-specific needs, and evolving changes in delivery systems. Today, approximately half (2,000) of these additional positions should be targeted to primary care and generalist disciplines; the remainder should be distributed across the dozens of the approximately 140 other specialties that an aging nation relies upon. Attempts to increase physicians in targeted specialties by reducing training of other specialists will impede access to care.**

   Approximately half (or 13,000) of first-year residency training positions are in family medicine, internal medicine, and pediatrics; while many of these residents will go on to subspecialize, the number of fellowship (or subspecialty) training positions accounts for approximately 20 percent of all available GME slots. Even the largest internal medicine subspecialty, cardiology, trains fewer than 1,000 physicians a year; less than 500 oncologists are trained annually. Attempting to force physicians to forgo subspecialty training by limiting fellowship opportunities would have limited effect and, even if successful, would jeopardize timely access to care for patients who require a subspecialist.

   Wait times for access to subspecialists continue to grow, necessitating that, in some cases, training capacity must be increased combined with efforts to more efficiently use subspecialty care. The AAMC believes that the ideal team-based health care delivery and utilization model should efficiently use human resources to improve patient access to appropriate services. For example, some patients managed by specialists can be directed back to primary care providers with management plans for chronic conditions. Other providers in a variety of settings could care for lower acuity patients now treated by physicians. Optimizing utilization will help relieve both the burden on patients seeking to access appropriate health care services and on overwhelmed providers, but will not obviate the need to train more doctors.

Physician shortages will persist even if the Medicare funding caps are lifted today, given the severity of the problem and a likely modest rate of change in the delivery and payment systems. Increasingly, patient access to both primary and specialty care will be a challenge. As health care is better integrated—team care expands and unnecessary variations are reduced—newly insured patients will present in the offices of primary care providers. For many of those patients, primary care providers will need to coordinate the care of subspecialists for complex illnesses. These needs will outstrip the supply of many subspecialties at current levels, even if utilization rates are significantly reduced.

It is unclear how extensive this increase in utilization will be over the course of subsequent years. Therefore, it is imperative to target the current and future increase in federally funded residency positions through ongoing analysis of health care utilization and estimates of future demand, rather than by prescribing a static specialty composition that does not actively respond to a dynamic health care environment.

3. **In addition to expanding support for GME, policy makers should leverage clinical reimbursement and other mechanisms to affect geographic distribution of physicians and influence specialty composition.**

While the ACA took steps to increase reimbursement to primary care providers, policy makers will need to reimburse cognitive and patient management services in a way that makes these specialties more attractive to new physicians. Similarly, programs like the Title VII health professions programs and the National Health Service Corps (NHSC) have successfully improved distribution of primary care providers to underserved areas, but policy makers must find ways to reward physicians economically who serve geographically or economically underserved communities. Education and training cannot overcome the intense market incentives that influence physician choices.

Recent studies show 31 percent of physicians are not accepting new Medicaid patients. Teaching hospitals and physician faculty are more likely to serve poor and vulnerable populations and will be asked to see more patients for whom reimbursement is less than the cost of providing care. Physicians and other providers must be paid adequately to ensure that patients have access to care.

4. **The federal government should continue to invest in delivery system research and evidence-based innovations in health care delivery.**

Lifting the 15-year freeze in federal support for physician training by 15 percent would only meet one-third of the expected shortage of physicians by the end of this decade, and is insufficient to ensure access to care. Delivery system innovations that improve efficiency, integrate care, and leverage other health professionals also will be necessary.

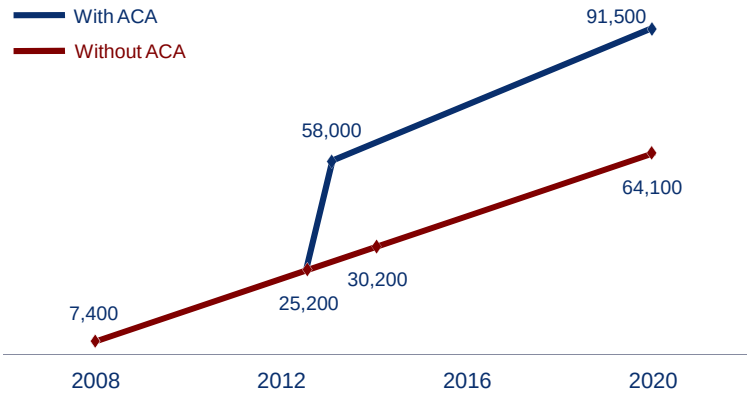
The ACA created new opportunities for health care delivery reform at the federal level and for the states, which are now in the beginning stages of implementation. AAMC institutions and faculty are working with the federal government to improve delivery and payment by participating in physician group practice (PGP) demonstrations, high-cost beneficiary demonstrations, the Center for Medicare and Medicaid Innovation's (CMMI) Pioneer Accountable Care Organization (ACO) program, and CMMI Health Care Innovation Awards. AAMC members are focused on the transformation of health care delivery, including through the Patient-Centered Outcomes Research Institute (PCORI) established by the ACA. Nationally, AAMC has partnered with other health education associations through the Interprofessional Education Collaborative (IPEC) to prepare the health workforce for collaborative practice and team-based care.

AAMC teaching hospital members receive significant public funding for their missions and are willing to be meaningfully accountable for that support. The training of physicians and other health professionals has changed significantly in the last 15 years and is increasingly focused on teaching doctors to improve systems of care. As measures are created, tested, and evaluated, these data will demonstrate the increasing ability of new physicians to work in teams; facilitate system changes to improve population health; and foster continuous quality improvement.

Continued research will inform how providers, systems, and payers can ensure access to care as well as optimal outcomes. Along with the AAMC, the federal government should continually assess how these delivery changes affect workforce needs and make the necessary additional investments in training to provide an adequate physician workforce.

Figures

Figure 1: Projected physician shortages



Source: Kirch DG, Henderson MK, Dill MJ (2011). "Physician Workforce Projections in an Era of Health Care Reform." *Annual Review of Medicine.*

Figure 2: Projected first-year enrollment growth through 2020