CAFP POSITION PAPER:

PRIMARY CARE PHYSICIAN WORKFORCE IN CALIFORNIA

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CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

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An expanded primary care physician workforce is necessary to meet our State's population health needs and to address the priorities of health equity, better patient outcomes and experience, and reductions in health care spending. There are four pillars to expanding the primary care physician workforce in California – pipeline, graduate medical education, practice transformation, and payment reform.

Pipeline

EXPANDING AND SCALING PIPELINE PROGRAMS

Expanding the primary care physician workforce begins with expanding and scaling pipeline programs to identify, recruit, prepare, and retain students and residents from underrepresented and low-income communities for careers in primary care. Activities should include:

- Exposing elementary, high school, and college students, particularly in underrepresented and low-income communities, to high quality primary care practices and physician role models.
- Enhancing participation of primary care physicians on medical school admission committees to identify students who are more inclined toward primary care (e.g., those with more service orientation and those from rural and low-income families).
- Enhancing outreach and mentoring programs designed to sustain interest in primary care throughout medical school and residency.

Graduate Medical Education

INVESTING IN FAMILY MEDICINE RESIDENCY PROGRAMS

California has historically underfunded residency positions, but the problem is particularly acute in primary care. Based on 2018 data, California ranked 37th in the nation at 10.6 primary care residents per 100,000 population; in contrast, New York ranked first at 33.1.[1] As such, there is a need for greater investment in primary care residencies. Especially given that over the next decade it is projected that California will have 10 percent fewer primary care providers than the number needed to maintain current rates of utilization of primary care services.[2]

Residency programs are highly subsidized with funding from federal and state government. For instance, without Song-Brown Program funding, many family medicine residency programs would be at risk of closure. Funding for family medicine residency programs is critical for access to primary care especially in underserved communities. Each family medicine resident provides an average of at least 600 additional patient visits per year. And many of these residents are in programs that provide care in underserved communities, which is a long-term benefit for those communities, as many of the of family medicine residents stay and practice in those communities. Moreover, family medicine represents the best value for primary care investments, because family physicians are the only medical specialty who almost exclusively provide primary care services, with a very low percentage of graduates who go on to subspecialize outside of primary care. About 80 percent of internal medicine physicians[3] and about 40 percent of pediatricians subspecialize.[4]

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1 State Physician Workforce Data Report, ASSOCIATION OF AMERICAN MEDICAL COLLEGES (2019), available at https://www.aamc.org/data-reports/workforce/data/2019-state-profiles.

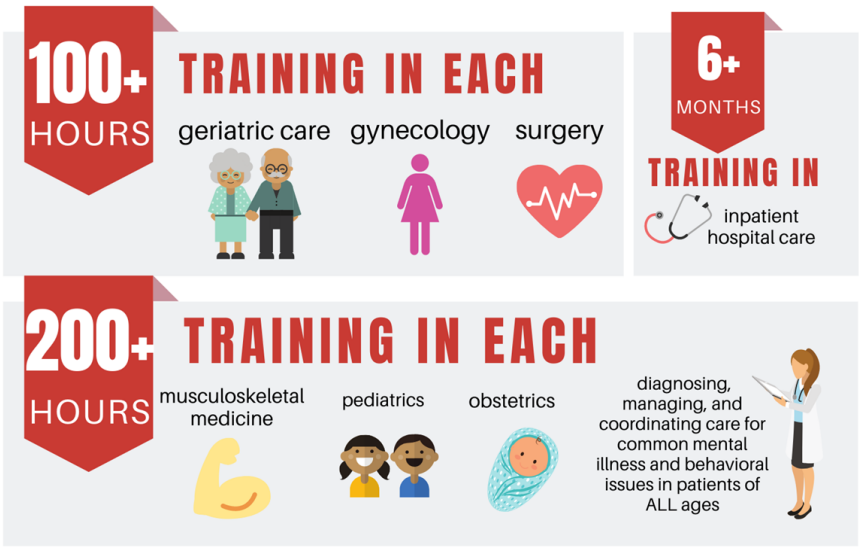
2 Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission, California Future Health Workforce Commission (February 2019), available at https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf.

3 Number of Candidates Certified, American Board of Internal Medicine website at https://www.abim.org/about/statistics-data/candidates-certified.

4 Data and Workforce, American Board of Pediatrics website at https://www.abp.org/content/data-and-workforce.

LOOKING TO FAMILY MEDICINE TO IMPROVE ACCESS TO PRIMARY CARE SERVICES IN UNDERSERVED AREAS

Family medicine physician education is extensive. Family medicine physicians receive specialized training in preventive and primary care for people from birth to end-of-life. This comprehensive training makes family physicians unique in their breadth of knowledge and ability to provide high-value primary care to patients of all ages and with a broad range of acute and chronic physical and psychosocial conditions, including multiple chronic conditions. Family physicians are the usual source of care for about 20 percent of children in the United States.[5] Family physicians also deliver clinical preventive services, provide patient education, and coordinate care with other providers. This broad skill set is particularly valuable in communities or geographical areas where certain specialists and subspecialists may not be available. Much of the primary care that are done by specialists can be provided by family physicians. The breadth and depth of their training allows family physicians to adapt their practices to meet the specific medical needs of their community.



Moreover, though family physicians comprise a smaller proportion of the U.S. outpatient physician work force[6], they comprise almost the majority of the visits to physicians' offices in rural areas.[7] Among primary care physicians, family physicians and general practice physicians are more highly concentrated in rural areas compared to geriatricians, internists, and pediatricians.[8] A study from the Robert Graham Center indicated that, if family physicians were removed from the 1,548 rural U.S. counties that are not Primary Care Health Personnel Shortage Areas (PCHPSAs), 67.8 percent of those counties would become PCHPSAs. On the other hand, removing all general internists would make only 2.1 percent of the counties PCHPSAs, and only 0.5 percent would become PCHPSAs without pediatricians or without obstetrician-gynecologists.[9]

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5 Primary Care in the United States: A Chartbook of Facts and Statistics, Robert Graham Center (February 2021), available at https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf.
6 A Primary Care Perspective on Health Care Workforce and Expenditures, Robert Graham Center (2009), available at https://www.graham-center.org/content/dam/rgc/documents/publications-reports/presentations/RGC-Update-PDF.pdf.
7 Ginger Ruddy et al., *The Family Physician Workforce: The Special Case of Rural Populations,* Robert Graham Center (July 1, 2005), available at https://www.graham-center.org/rgc/publications-reports/publications/one-pagers/workforce-rural-2005.html.
8 Supra note 5.
9 Susan Dovey, Larry Green, & Ed Fryer, T*he United States Relies on Family Physicians, Unlike Any Other Specialty,* Robert Graham Center (May 1, 2001), available at https://www.graham-center.org/rgc/publications-reports/publications/one-pagers/rely-fps-2001.html.

Practice Transformation

CHANGING THE WAY CARE IS DELIVERED

Primary care has experienced significant changes in the way it is organized, financed, and delivered in response to greater demand for high-quality services, rising health care costs, and increasing burden of disease across populations. One of the changes that emerged was the concept of the Patient-Centered Medical home (PCMH) to describe a more advanced model of primary care. The PCMH is a health care delivery model in which health care providers (doctors, nurses, physician assistants, medical assistants, mental health providers, community health workers, social workers, etc.) work in partnership with one another, their patients, and their patients' families to coordinate care, navigate the complex and often confusing health care system, and ensure that patients receive the right care at the right time. Care provided in PCMHs is patient-centered, team-based, coordinated, accessible, comprehensive, continuous, planned, equitable, and high-value. Care that focuses on these principles will achieve the goals of better patient outcomes and experience, reduced health care spending, and improved physician satisfaction. Improved physician satisfaction in primary care will support recruitment of physicians to practice in primary care, prevent burnout, and promote retention.

Payment Reform

INVESTING IN PRIMARY CARE

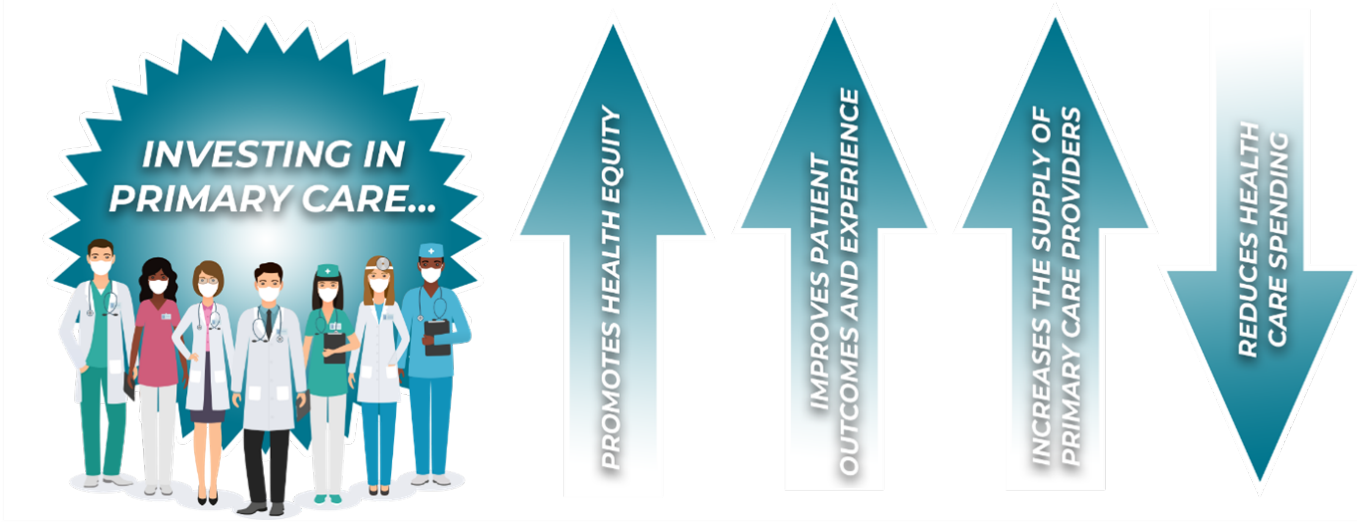
There is consistent and growing evidence that investing in primary care promotes health equity, improves patient outcomes and experience, increases the supply of primary care providers, and reduces health care spending. Despite this strong evidence, primary care has been chronically underfunded. California spends from 6.1 percent to 10.8 percent on primary care, while the average among OECD countries is 14 percent.[10] A Commonwealth Fund analysis identified underinvestment in primary care as one of four fundamental reasons the U.S. health system ranks last among high-income countries.[11] Accordingly, a greater percentage of medical spending needs to be dedicated to primary care.

Moreover, the current predominant payment scheme of fee-for-service payments is not structured to support or sustain a comprehensive primary care system. Hence, there also needs to be a shift from fee-for-service payments, which promotes volume over value, to alternative payment models that promote population health management; coordinated, comprehensive, high-value care; and greater investment in primary care.

In a primary care initiative launched by the self-insured Fresno Unified School District/Joint Health Management Board and the California Academy of Family Physicians that included an alternative payment model, the district saved nearly $1 million and health outcomes and patient satisfaction improved significantly one year after the launch of the initiative.[12] Savings were in part due to a three percent decrease in emergency department visits and a 22 percent decrease in inpatient admissions. Other states that have invested in primary care have also seen significant reductions in expenditures. Oregon found that for every $1 increase in primary care expenditures resulted in $13 in savings in other services, such as specialty care and emergency department and inpatient care.[13] In addition, Oregon saved an estimated $240 million over the first three years of the initiative.

Investing in primary care can also increase the supply of primary care providers. Rhode Island experienced an increased supply of primary care providers per capita during the time period in

10 Investing in Primary Care: A State-Level Analysis, Patient-Centered Primary Care Collaborative and Robert Graham Center (July 2019), available at https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf.
11 Eric C. Schneider and David Squires, *From Last to First – Could the U.S. Health Care System Become the Best in the World?, THE COMMONWEALTH FUND (July 17, 2017),* available at https://www.commonwealthfund.org/publications/journal-article/2017/jul/last-first-could-us-health-care-system-become-best-world.
12 Patient Centered Medical Home: Community Medical Providers' Success, California Academy of Family Physicians (2014), available at https://www.familydocs.org/wp-content/uploads/2020/11/FresnoPCMHPilotReport2014.pdf.
13 Sherril Gelmon, et al., *Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings,* Portland State University (September 2016), available at https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf.



which the state increased primary care investments.[14] An increased supply of primary care providers is associated with improved health outcomes and life expectancy. Research published in 2019 found that having ten additional primary care physicians in an area was associated with a 51.5-day increase in life expectancy.[15] Increasing the supply of primary care providers and thereby increasing access to preventive and primary care also narrows health disparities and promotes health equity.

Half of all physician office visits are to primary care physicians, and primary care providers provide the majority of visits for most people with chronic conditions, yet the primary care physician workforce in the United States is only about one-third of the physician workforce proportionally smaller than many international peers. Production of primary care physicians relative to specialty physicians has been in steady decline for decades.[16] In order to build the primary care physician workforce, California must invest in primary care graduate medical education, look to family medicine to improve access to primary care services in underserved areas, and change how we deliver care and pay for primary care.

14 Supra note 10.
15 James Macinko, Barbara Starfield, & Leiyu Shi, *Quantifying the Health Benefits of Primary Care Physician Supply in the United States, 37(1) INT. J. HEALTH SERV. 111-126* (2007), available at https://www.researchgate.net/publication/6391542_Quantifying_the_Health_Benefits_of_Primary_Care_Physician_Supply_in_the_United_States.
16 Supra note 5.

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