America’s facing a shortage of primary-care doctors

By Emma Court
On April 4, 2016
http://www.marketwatch.com/story/americas-1-million-doctor-shortage-is-right-upon-us-2016-04-01

Shortfall is growing especially acute in rural areas

The doctor will not see you now. The U.S. could lose as many as 100,000 doctors by 2025, according to a recent Association of American Medical Colleges report. Primary-care physicians will account for as much as one-third of that shortage, meaning the doctor you likely interact with most often is also becoming much more difficult to see.

Tasked with checkups and referring more complicated health problems to specialists, these doctors have the most consistent contact with a patient. But 65 million people live in what’s “essentially a primary-care desert,” said Phil Miller of the physician search firm Merritt Hawkins.

Without those doctors, our medical system is “putting out forest fires — just treating the patients when they get really sick,” said Dr. Richard Olds, the chief executive officer of the Caribbean medical school St. George’s University, who is attempting to use his institution’s resources to help alleviate the shortage.

Dr. Ramanathan Raju, CEO of public hospital system NYC Health + Hospitals, goes even further, saying the U.S. lacks a basic primary-care system. “I think we really killed primary care in this country,” said Raju. “It needs to be addressed yesterday.”

The primary-care gap is particularly acute in about one-third of states, which have only half or less of their primary-care needs being met. Connecticut is a standout among the group, at about 15%, with Missouri, at 30%; Rhode Island, at 33%; Alaska, with 35%; and North Dakota, at 37%, next on the list, according to government statistics.

“The real problem is we don’t have enough doctors in the right places and in the right specialties,” Olds said, noting that doctors tend to cluster in big cities, and are far more scarce in rural areas and in other small communities as well as certain parts of some big cities.
But how did this shortage come about, and how has the problem gotten so acute?

Here’s what’s involved:

- **How doctors are paid**: Choosing to go into primary care is also a choice of lesser pay. Starting salaries in high-paying specialties can range from $354,000 (general surgery) to $488,000 (orthopedic surgery), while primary-care fields tend to bring a sub-$200,000 starting salary, from $188,000 (pediatrics) to $199,000 (family medicine), according to a Merritt Hawkins report.

  The pay disparities reflect America’s “fee for service” health-care model, which compensates providers based on the number and type of services they complete, and which inherently favors specialists.

  Reform-minded critics say compensation should instead be based on the period of time a patient is cared for. They argue that this structure would incentivize preventative care and prevent unnecessary (and often costly) medical procedures. The Centers for Medicare and Medicaid Services is in the very early stages of considering this global payment model.

  Experts say it’s not just that primary-care doctors are paid less; they also typically work longer hours and have to be well-versed in a wide array of medical issues, to refer patients to the appropriate specialists.

  Our culture is also part of the problem, Raju said, since “it’s not very glamorous to [say] that I went to some primary-care doctor. It’s glamorous to say, ‘I went to a cardiologist.’”

  Paired with hundreds of thousands of dollars of debt, it’s a recipe for a shortage, Olds said.

  “From the patient standpoint, the most important doctor you have is the primary-care doctor, who’s paid the least,” Olds said. “We pay for procedures, drugs and expensive tests, but we don’t pay doctors to think and care and manage patients’ health-care problems.”

- **More demand**: People are living longer and thus need more medical care, accelerating doctor demand; AAMC’s 2015 report calculates an 11% to 17% growth in total demand, of which a growing and aging population is a significant component.

  The shortage is one that’s been stewing for decades but of late was exacerbated by passage of the Affordable Care Act, which increased the number of insured people and along with that the demand for doctor access, experts say.

- **Medical schools themselves**: Few medical schools consider a community-service background or an expressed interest in primary care when admitting applicants, though these are factors that would be easy to screen for. Past service in programs such as the Peace Corps and Teach for America are good predictors of students taking an interest in primary care, Olds said.

  Diversity also plays a role. Olds said he’s found that students from a range of socioeconomic backgrounds tend to go into a diversity of medical fields, too.

  Then there’s the structure of the programs themselves. A majority of med-school faculty members tends to be composed of specialists (a more research-oriented bunch, aiding the school’s federal funding), which influences their students’ choices, and use of university hospitals as teaching sites doesn’t immerse students as much in the outside community, inhibiting growth of community roots.

  Osteopathic schools — which have the same educational requirements as an M.D. degree institution but with a focus on holistic medicine and a more hands-on approach — tend to have more luck sending
students into primary care, with over half of graduates going into nonspecialized fields, said Dr. Barbara Ross-Lee, dean of the New York Institute of Technology’s new osteopathic medical campus at Arkansas State University.

The NYIT ASU campus was founded to alleviate Arkansas’s physician shortage and will enroll its first class of 115 students in August.

Like other osteopathic schools, the NYIT ASU degree program will focus on patients’ overall wellness, an approach that dovetails with the philosophy and role of a primary-care doctor.

But osteopathic programs are also designed to expose students to general medicine, with generalists making up much of the teaching faculty and clinical training opportunities in settings where primary care is delivered. The school also asks students in entrance interviews about their interest in primary care, Ross-Lee said.

- **Geography:** It doesn’t take more than a quick scan of a map of medical schools in the U.S to note that they’re heavily concentrated in the northeastern U.S. Graduates tend to stay in the areas where they went to school, so this contributes to a geographic skew among doctors.
  Prospective doctors must complete a residency in order to practice medicine, but those programs — funded in part by federal dollars — aren’t located in areas with great need nor do they geographically calibrate with that factor in mind.

  Pay figures in, too. Suburban areas typically offer a perceived higher quality of life to doctors and their families, along with, often, better compensation than a public, urban system, said Raju, resulting in shortages even in places such as his own hospital system in New York City.

- **The government’s role (or lack thereof):** In the U.S., though government dollars sponsor aspects of medical education, especially residencies, there’s no oversight in how doctors are sorted into various specialties.
  But fingers aren’t just pointing at medical schools. Fear of a doctor surplus prompted a 1997 payment cap on Medicare funding for residencies, which has served as a “stumbling block” for doctor training ever since, John Iglehart wrote in the New England Journal of Medicine in 2013.
  So as medical-school enrollment has swelled — medical schools planned to increase their enrollment classes by almost 30% between 2002 and 2016, according to Iglehart — residency-slot expansion has slumped.

- **A numbers game:** Only about one in four medical-school graduates is heading into a primary-care career, according to Olds, a ratio that’s half what it should be.
  But doctors also want to practice differently today than their predecessors did, placing a higher premium on regular, 9-to-5 hours, Miller said. So “we find it takes more than one doctor coming out today to replace an old-style, baby boomer doctor [of 25 years ago],” he said.

  Then there’s the seven years it takes to train a doctor — a lag time that’s built into any program or effort to address the shortage.

  That means there’s little wiggle room. “The time is now,” said Ross-Lee.