



The shortage of physicians and the implications for PAs

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On January 30, 2006, the American College of Physicians (ACP) released a highly publicized report that predicted “the impending collapse of primary care.”¹ With many primary care physicians heading toward retirement and fewer young physicians choosing to go into primary care, our nation may well face an impending shortage of primary care physicians. While the ACP has proposed several reforms to help avert the impending crisis, it did not address the role of physician assistants and other nonphysician clinicians (NPCs) in their recent report.

A historical perspective

In his excellent 2004 overview of the physician-supply debate, David Blumenthal traced multiple predictions of medical workforce disaster, beginning with the Flexner report in 1910.² At that time, the United States was felt to have an oversupply of poorly trained physicians, and the Flexner report led to the closing of many medical schools across the country, with a resulting decrease in new physicians. This restrictive policy continued throughout the first half of the 20th century.

Then in 1959 came the Bane report from the Surgeon General’s Consultant Group on Medical Education, which predicted a severe shortage of physicians by 1975. This report led to a shift in public policy and a corresponding growth in both the number and class size of medical schools. Between 1965 and 1980, Blumenthal reports, the number of annual medical school graduates more than doubled, to around 15,000 per year.² This period of physician shortages also saw the birth of a new career—the PA—with the first class of three PAs graduating from Duke University in 1967.

Attempts to predict future supply of and demand for physicians increased in sophistication in 1981 with release of the report of the Graduate Medical Education National Advisory Committee (GMENAC).³ This distinguished

panel of experts predicted a worrisome surplus of physicians by the year 2000. Although the GMENAC report led to a loss of federal support to medical schools and resulted in a stable number of US physician graduates, the 1983 Medicare reforms tied extra payments to teaching hospitals to the number of physician trainees. This resulted in an increase in the number of residency slots, many of which were filled by an influx of foreign medical graduates, and, paradoxically, the number of resident physicians trained in US hospitals actually grew substantially during the 1980s and 1990s.

After GMENAC came a series of reports by the Council on Graduate Medical Education (COGME) in the early 1990s. These reports and others continued to predict a surplus of physicians, particularly in specialty areas. Workforce experts felt that the “managed care revolution” during the mid-1990s would worsen the impending surplus since HMOs apparently were able to care for larger numbers of patients with fewer physicians.⁴ Once again, Congress responded to warnings of impending physician over supply: in 1997, the Medicare program capped the number of available residency slots.

Dissenting voices were heard over the 20 or so years of predicted physician surpluses, but public policy was based consistently on the conventional wisdom that growth of physician supply would surely outstrip demand by the year 2000. However, the year 2000 arrived, and the predicted glut of physicians did not. Abruptly, it became clear that critics such as Richard Cooper, founder of the Health Policy Institute at the Medical College of Wisconsin, might actually be on the right track in predicting that the US demand for physicians in the 21st century will considerably outpace supply.⁵

The past several years have seen a dramatic about-face by health policy analysts and by many medical organizations. The most recent report by COGME, released in January 2005, forecasts that there will be a significant shortage by the year 2020.⁶ Interestingly, this recent report by COGME states specifically that a potential increase in the supply and use of PAs, NPs, and other NPCs was not included as a factor in their projections.

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Support for ACP claims

In its 2005 report, COGME identified several factors driving the increase in demand for physicians.⁶ Most important, the US population is projected to increase by around 18% between 2000 and 2020, while over the same period the number of Americans older than 65 years is projected to grow from 35 million in 2000 to 54 million in 2020. And the older-than-85 population—most of whom require care for multiple chronic conditions—is expected to increase 50% between 2000 and 2010. On the other side of the equation, COGME predicts a 24% increase in practicing physicians between 2000 and 2020 but expects the population growth to exceed the growth in number of physicians, particularly after 2010. A key contributing factor is the aging of the current physician population.¹

Additionally, fewer medical students are choosing to pursue residency training in primary care disciplines.^{7,8} Between 2000 and 2004, there was a 33% drop in the number of medical students matching to primary care internal medicine training programs and a 35% drop in students matching to family medicine residency programs.⁸ Trainees report a variety of reasons for avoiding primary care, including the perception of job dissatisfaction among current primary care practitioners. Other factors cited as reasons to avoid primary care include lack of prestige, lower income potential, difficult paying off school debt, and greater stress.⁸

PAs and other nonphysician clinicians

Missing from most recent discussions of the “impending collapse” of primary care in this country is discussion of the role played by PAs and other NPCs. Dr. Cooper, among the first to predict physician shortages, does include the trend toward increased utilization of NPCs in his model, noting that PAs, NPs, and other clinicians “now provide services that broadly overlap with those provided by physicians.”⁵ He predicts that there will be around 275,000 PAs, NPs, and nurse-midwives in the workforce by 2015, which will buffer but not negate the impending physician shortage. Cooper also predicts that a protracted shortage of physicians is likely to expand autonomy and scope of practice among NPCs, particularly in states where practice laws are currently most restrictive.

Changes in medical school admissions policies take years—historically, as many as 15—to translate into more available practicing physicians, while PAs enter the workforce after 2 to 3 years of training. Whether new PA graduates will choose to locate in specialties and geographic areas undersupplied with physicians is unclear. There is a definite trend over the past few years toward new PA graduates’ entering specialty practice, perhaps for the same lifestyle reasons as their physician colleagues. In 2004, only 38% of new PA graduates took jobs in primary care, down from a peak of 62% in 1996.⁹

On the other hand, for economic reasons, new PA graduates do tend to go where the jobs are. Preliminary evidence also suggests that PAs tend to locate in rural areas less favored by physicians.^{10,11} At any rate, it seems likely that the predicted physician shortage will increase utilization of NPCs and is likely to further promote the concept of team practice in medicine.

While PAs and other NPCs may well cushion the impact of future physician shortages, even with increasing numbers of new graduates, PAs are still a small piece of the puzzle. The bigger issue is the health of the US medical system overall—with new physician graduates focusing more on lifestyle issues, major reform may be required in order to address the financial, legal, administrative, and bureaucratic pressures that diminish career satisfaction for medical providers.

One last factor to consider is that the projected shortage of physicians will undoubtedly have its greatest impact on those groups in our society that have always been medically underserved: rural populations, poor communities, minorities, and the uninsured. It is both ironic and disturbing that the societal factors that originally led to the birth of the PA profession in the 1960s appear poised to support the continued growth of the profession well into the 21st century. □

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Editor's note: AAPA has long been an active participant in the debate over physician supply. *The New England Journal of Medicine* published a letter from AAPA Executive Vice President/CEO Steve Crane in August 2004 that stated in part: “It is time . . . to move beyond the physician as the principal unit of analysis in workforce studies. The more appropriate unit of measurement should be the medical services needed . . . to meet patients’ requirements. When this is the case, the analytic question becomes . . . how we can most effectively produce the required services with a variety of . . . resources, such as physician assistants.”