Caring for the Uninsured and Underinsured

Primary Care Physician Supply and the Medically Underserved

A Status Report and Recommendations

Robert M. Politzer, MS, ScD; Dona L. Harris, PhD; Marilyn H. Gaston, MD; Fitzhugh Mullan, MD

QUALITY health care for all Americans has been viewed as an individual right rather than a privilege. Today, many Americans lack access to an ongoing source of primary care and, therefore, to essential clinical preventive services. Differences in health status between subsets of our population continue to be a national embarrassment.1 Providing equal access to primary health care has been a problem for this nation throughout its history.

What is needed . . . is a body of information and general principles concerning man as a whole and man in society that will provide an intellectual framework into which the lessons of practical experience can be fitted. This background will be partly biologic, but partly it will be social and humanistic, for it will deal with man as a total complex, integrated, social being. Medical schools and teaching hospitals should prepare many more physicians than now exist who will have the desire and the qualifications to render comprehensive, continuing health services, including preventive measures, early diagnosis, rehabilitation and supportive therapy, as well as the diagnosis and treatment of acute or episodic disease states.2

During the 1960s, the Willard and Folsom commissions, echoing the Millis report, recommended that additional physicians be trained, in part because of a projected decline in the number of general practitioners and a concurrent increase in the number of physicians specializing. As a result, several events transpired that influenced medical schools and teaching hospitals to place greater emphasis on primary care:

- Recognition of family practice as a medical specialty;
- The establishment of a number of new state-supported medical schools with mission statements that included primary care training and the multidisciplinary team approach as central themes;
- Federal funding for primary care training, including physicians, dentists, nurses, nurse-practitioners, certified nurse-midwives, and physician assistants;
- Federal scholarship support for medical education through the National Health Service Corps (NHSC); and
- Federal support for community and migrant health centers.

In 1971, the federal government, through Title VII of the Public Health Service Act, began supporting the training of primary care physicians when it recognized that segments of the nation's population were not receiving and had no access to primary care. The legislation enabling support of training was based on the assumption that an increase in the aggregate supply would produce an increase in its generalist and primary care components and alleviate geographic shortages in the availability of primary care services.

Directed by these assumptions, federal training support initially focused on producing an increased number of well-trained primary care physicians and paid relatively little attention to incentives to practice in underserved areas. During the evolution of the training grant programs, funding incentives or priorities were offered to prospective grantees who demonstrated a commitment to providing primary care services in medically underserved areas. The Area Health Education Centers were initiated in 1972 to address specialty maldistribution, particularly in rural areas.3

To provide one-door primary care services directly to medically underserved and disadvantaged populations, the federal government supported the development of community and migrant health centers.4 Despite their rapid growth and continued support in the 1970s, these centers had difficulties recruiting and retaining a sufficient number of physicians. To improve the delivery of services where health personnel were inadequate, including community and migrant health centers, and an identifiable unit within the Public Health Service was established—the NHSC.5

In 1976, the Health Professions Education Assistance Act (PL 94-484) included a number of provisions intended
to ease geographic and specialty maldistribution. This legislation greatly increased funding authorizations for the NHSC and its scholarship program and augmented primary care training support.

The 1980s brought reductions in federal support and cost-containment policies and strategies that were to have a profound effect on the training and distribution of health professionals and ultimately on access to care in underserved areas. The forecasted oversupply of physicians by the Graduate Medical Education National Advisory Committee lured policymakers and educators into the assumption that diffusion of primary care providers would eventually alleviate manpower shortages.

To a large extent, the continuation of the community and migrant health centers network was dependent on the supply of well-trained NHSC providers. The reduction in support for the NHSC coupled with the increased competition from large managed-care systems' forced community and migrant health centers to marshal new strategies for recruiting and retaining providers. The NHSC has recorded retention rates in areas with shortages ranging from as high as 50% to as low as 10%, depending on the definition of retention. However, the number of areas with shortages and the number of providers needed to eliminate shortage area designations have remained constant, at 1900 and 4200, respectively. Dwindling federal financial support of the NHSC during the latter half of the 1980s jeopardized its field strength. Although recent legislation has substantially increased support for the NHSC, it is likely that several years will pass before there is a significant impact.

Studies have demonstrated that primary care physicians trained as Millis described have substantially improved access to care for minorities, the poor, and those living in inner cities and rural areas. Graduates in general internal medicine provide care to a previously underserved part of America, treating more elderly, nonwhite, low-income, and "underinsured" individuals. Pediatric primary care graduates have entered practice in underserved urban areas in greater proportions than graduates of traditional programs in pediatrics. Family practice graduates have established rural practices in much greater numbers than physicians in other specialties.

Despite these successes, years of support for primary care training, and the widely recognized need for more physicians to enter primary care, there has been no significant increase in the proportion of medical school graduates who ultimately select primary care careers. More important, experts believe the situation will deteriorate because interest in primary care careers, both by premedical students and by medical students, is waning. In the early 1980s, nearly 40% of graduating seniors chose primary care careers. By 1989 that percentage had dropped to about 25.13

Physicians are choosing high-paying, technology-based specialties in place of the primary care specialties, particularly general/family practice. Rather than moving into underserved or unserved areas, even generalists are concentrating in large academic health centers. Two partial exceptions to this trend are the specialty and practice choices of osteopathic physicians and underrepresented minority physicians, a majority of whom still go into primary care and often serve in rural or other underserved communities.14 It is appropriate to concentrate less on the aggregate physician supply and more on preparing and making that supply available and accessible to those most in need.

This article discusses the current status of the primary care physician supply, the pending erosion of that supply, the role of the federal government in the training of primary care physicians, the difficulties of financing primary care training, and the influence of community-based training on career decisions. It then recommends courses of action to stem erosion and produce an adequate supply of primary care physicians to serve in the most severely underserved areas. The authors predicate their discussion and recommendations on the following assumptions:

1. Although economic forces define many of the realities of health care for underserved areas, other factors also influence a physician's decision and ability to practice in such communities. These factors can be addressed in a training program, and such a program can prepare and encourage physicians to practice in such settings after residency training.

2. Although it has been argued that physicians trained in several other specialties may deliver primary care, our analysis will focus on the specialties that specifically prepare participants for the delivery of primary care: family practice, general internal medicine, and general pediatrics.

CURRENT STATUS OF THE PRIMARY CARE PHYSICIAN SUPPLY

Despite the rapid expansion and development of allopathic primary care residency programs over the last two decades, there is a serious imbalance between the production of primary care physicians and those in other specialties.15 The number of active allopathic primary care physicians has grown no faster than the pool of all physicians.16 During the 1980s, about 33% of all active physicians were primary care physicians, declining slightly during the decade, from 33.0% in 1981 to 32.7% in 1986. This rate of growth is the product of a continued but slight decline in the representation of general/family physicians, from 13.5% in 1981 to 13.0% in 1986, coupled with a steady representation in general internal medicine (13.4% in 1981 and 1986) and general pediatrics (6.4% in 1981 and 6.2% in 1986).17

The rate of growth of the supply of allopathic primary care physicians has been considerably slower than the rate of growth of the pool of physicians trained in the subspecialties of internal medicine and pediatrics.18 The remarkable increase in subspecialty training since 1971 is reflected in forecasts of the supply of general internists vs subspecialists based on the differential in their growth rates. During the 20-year period from 1978 to 1998, the number of general internists is expected to increase by 77%, whereas the number of subspeciality internists is expected to increase by 205%.19

Osteopathic physicians account for 3.9% of all US physicians (Because this represents such a small fraction of both the total and primary care physician pools, we will only address the allopathic physician specialty supply), but they represent 9.3% of physicians in primary care. An increasing number of osteopathic physicians are also entering the non–primary care specialties.20

Health Professions Shortage Area designations are often used as a barometer for assessing changes in the availability of primary care physicians. During the middle to late 1980s, improvement in the distribution of primary care physicians was reflected in the continued decline in the number of physicians needed to reduce the number of areas with shortages, from 4625 in 1984 to 4104 in 1988. However, this number has begun to climb for the first time in 10 years, and in 1990 it exceeded 4200.21 The prognosis for the primary care specialties led the Council on Graduate Medical Education to conclude that, if these trends continue, the number of physicians graduating from primary care graduate medical education programs will be considerably lower than projected by the Graduate Medical Education National Advisory Committee, and projections of undersupply may
be warranted.20

The most recent information provided to the Department of Health and Human Services by state governors indicates continuing shortages of primary care physicians throughout many areas of the country. Of the 55 states, commonwealths, and territories that responded to the Department of Health and Human Services about health manpower shortages, 49 (89%) cited general shortages of primary care physicians. Moreover, 45 (82%) also identified shortages of primary care physicians in rural areas.21

However, primary care physician supply, as a proportion of the total supply of physicians is expected to remain constant. Forecasts by the Bureau of Health Professions reveal that the primary care physician supply will likely continue to grow at the same rate as the overall physician supply.19 These forecasts assume that the primary care specialties will continue to garner the same percentage of total first-year residency positions as was observed from 1986 through 1988.

The forecasts also assume that the fourth-year subspecialty selection rate for residents completing the third year of a general internal medicine or general pediatrics residency will remain constant. Despite an initial preference for general internal medicine, only about 40% of those who initiate such training become general internists. This figure reflects the pattern observed in the middle 1980s.22 However, data on the specialty preferences of today's students presented below portend a decline in the percentage of first-year residents in family practice and further erosion in the fraction of third-year primary care residents who select primary care careers.

**DIMINISHING INTEREST IN PRIMARY CARE SPECIALTIES**

Candidates to replenish the supply of primary care physicians are dwindling.

- The specialty preferences of US medical school seniors for a primary care career declined substantially during the 1980s. In 1981, 38.8% of the graduating class planned to become board certified in a primary care specialty, compared with 25.4% in 1989.19
- The proportion of medical school seniors planning to become board certified in general internal medicine dropped by more than 50%, from 12.7% in 1981 to 5.7% in 1989. Those planning to become board certified in family practice decreased from 17.3% to 13.7% during this period. General pediatrics showed a decline, from 8.8% to 6.4%.19
- Family practice fill rates for all match participants declined from 85.2% in 1984 to 70.4% in 1990. Match rates for all match participants declined for internal medicine and pediatrics. Although the non–primary care specialties of anesthesiology, general surgery, and neurosurgery also experienced declining fill rates, obstetrics/gynecology and orthopedic surgery recorded increases in fill rates to levels approximating 100%.23
- The eventual fill rate of approved family practice positions by July rose to 90.9% from the 70% fill rate obtained by the end of match day in March. However, this 90.9% figure represented the fourth consecutive year that the family medicine fill rate declined, from 98.5% in 1985 (C. Tsou, MD, assistant director, Division of Education, American Academy of Family Physicians, written communication, April 1990).26

It is apparent that the primary care specialties may not be able to sustain their current share of the physician supply. Declines in preference for family practice coupled with greater preferences for the subspecialties of internal medicine and pediatrics will produce an erosion in the percentage of residents who ultimately complete primary care training.

Other factors, coupled with diminishing interest, may exacerbate the imbalance in primary care vs subspecialty physician supply:

- Over the next several years, comprehensively trained primary care physicians, particularly board-certified family physicians, will be intensively recruited by health maintenance organizations, private group practices, community health centers, and other employers of physicians. This demand will significantly exceed the current and predicted supply of new family physicians. For people in remote rural areas, family physicians are the only practical source of physician care.32
- Continued growth of the health maintenance organization sector, with preferential recruitment of family physicians to support highly "cost-dependent" systems and the ability of health maintenance organizations to offer attractive salaries, leisure time, and career advancement, will dramatically and negatively affect recruitment of primary care physicians to areas with physician shortages.37
- Economic factors, particularly patient care reimbursement systems, uniquely affect primary care physician training programs. Teaching hospitals have found it increasingly difficult to sustain primary care residencies because they generate less revenue than inpatient-based, procedure-oriented residencies. Specialties that depend heavily on ambulatory training, especially family practice programs, are the most adversely affected because they are dependent on internal and external subsidies, such as federal and state support. Whereas other specialties recover a significant percentage of their operating costs through patient billing, family practice residency programs on average barely recover 30% of costs.25 Hospitals now meet an average of 81% of the costs of residency stipends from patient care income.26 Medical service income has become increasingly important to medical schools, growing from 12.2% of revenues in 1970 to 37.6% in 1987.22
- Specialty choices of graduates are correlated with specialty income potential.33 As long as primary care specialties are among the lower-paying specialties, they will find it difficult to attract future medical school graduates. Family physicians earn, on average, $87 000 per year, compared with about $193 000 per year for orthopedists.30 The customary, prevailing, and reasonable system of payment used under Medicare to reimburse physician services is now in the process of change to a resource-based relative value scale, which is anticipated to give increased value to the cognitive, nonprocedural services more often delivered by primary care physicians.22 Over a 5-year transition period, the fee schedule will play an increasing role in determining what physicians are paid, until all payments are based on the fee schedule in 1996.25 However, even with the changes in the fee schedule, large differences will remain between the annual salaries of primary care and specialty care physicians.34
- University-based family medicine residency training programs are filling their positions at declining rates (D. L.H., R. M.P., and M. H.G., unpublished data, January 1990).
- Ambulatory management of the human immunodeficiency virus epidemic will place increasing demands on the supply of primary care physicians. As patients are diagnosed earlier, management in the ambulatory care setting becomes more appropriate. In addition, the aging of the population, the loss of obstetrical care in rural areas, and the rising tide of immigration will compete for the primary care physician's time.

**FEDERAL ROLE IN THE TRAINING OF PRIMARY CARE PHYSICIANS**

Federal health professions legislation of the 1960s was targeted at and was successful in increasing the overall supply of physicians. An underlying assumption in this legislation was that an increase in the aggregate physician pool...
would include a concomitant increase in its generalist and primary care components. However, young physicians continued to turn to specialization in response to several factors, including the complexity of medical science, prestige of subspecialization, and anticipated income.

In response to the growing trend toward specialization, family practice was officially established in 1969 by the American Board of Medical Specialties as the 20th medical specialty. The Comprehensive Health Manpower Training Act of 1971 for the first time specified family medicine as a target for federal training grants. Despite this development and support, the output of family practice residency programs could not keep pace with rapid losses in the aging general practitioner population through the middle of the 1970s. It was not until 1980 that the general/family practice category recorded numerical increases. By 1988, this supply had barely reached the level of 70,000 recorded in 1965.30

Medical authorities concluded that, to reverse this trend, the proportion of medical students entering the primary care specialties of family medicine, general internal medicine, and general pediatrics should be 50%, a target that was later criticized by the Institute of Medicine as too low.31 The concern that this goal could not be reached without continued public sector support stimulated the passage of the Health Professions Education Assistance Act of 1976. Since 1972, grants have been awarded annually to provide partial support to about half of the family medicine residency programs. The first award of $5 million supported 52 of the 117 programs. By 1980, the number of family practice residency programs exceeded 380, residents numbered more than 6700, and awards totaled nearly $30 million. However, in 1981 appropriations were cut significantly and by 1982 had fallen to a level of less than $15 million, partially supporting about one fourth of the 388 existing residency programs. Since 1982, appropriations, not adjusted for inflation, have been relatively constant, and programs and residents have leveled at 384 and 7400, respectively. In real dollars, however, programs have received declining federal support. With the exception of the initial year of the program, funding in 1980 reached the lowest level in the program's 12-year history.32,37 Moreover, receipt of an average of $100,000 per program is less than 10% of these programs' costs.38

Beginning in 1977, the federal government began to support primary care residency training programs not only in family medicine but also in general internal medicine and general pediatrics. As was the case for family medicine, funding was cut severely in 1981, and there were no increases in overall funding levels throughout the 1980s.

**FINANCING PRIMARY CARE RESIDENCY TRAINING**

With the exception of family practice, most third- and fourth-year clinical medical education and residency training traditionally have taken place in hospital settings. Residency programs are financed primarily by third-party payments to the hospitals on a cost or charge basis. Hospital payments by private third-party payers for patient care include education costs.39

When Medicare's reimbursement procedure was changed from a retroactive, reasonable cost basis to a prospective payment method, an attempt was made to continue compensation for teaching hospitals through adjustments for salaries and benefits for residents and for other costs that were not fully covered in the new case classification system. For Medicare reimbursement, the hospital costs of graduate medical education were broadly categorized as direct and indirect. These categories amount to about $4.7 billion per year. Direct costs are primarily salaries and benefits for residents, a portion of faculty salaries, and overhead allocated by the hospital. Among the factors included in the indirect cost adjustment are severity of illness of patients requiring specialized services provided by teaching institutions, the increased use of ancillary services, and the cost of maintaining the availability of state-of-the-art testing and treatment facilities.40,41 However, these adjustments do not include compensation for training outside the hospital setting.

During the last two decades and stimulated most recently by Medicare prospective payment reform in 1983, many patient care services for diagnosis and treatment have shifted from hospital to out-of-hospital settings. This change in service delivery has produced an increasing demand to shift more educational experiences to outpatient sites. However, there is no mechanism within the Medicare graduate medical education reimbursement system to compensate institutions for education costs incurred outside of the hospital setting.42

Moreover, the ambulatory care third-party reimbursement system tends to discourage graduate medical education in ambulatory settings. Ambulatory practices contribute relatively little to hospital revenues. Services typically provided in such settings, including prevention and counseling, are not as well reimbursed as inpatient services. Payment levels are frequently lower for similar or identical services when provided in ambulatory settings. Patients also generally share a greater proportion of payments for services in ambulatory settings.

Federal grant funds are used as a primary source to initiate and improve ambulatory training. However, it is difficult for nominal federal grant support in the primary care arena to compete with the disincentives inherent in the Medicare graduate medical education reimbursement policy and the absence of sufficient revenues from ambulatory care third-party reimbursement.

**INFLUENCE OF FEDERAL FUNDING AND COMMUNITY-BASED EDUCATION**

It has been documented that physicians trained in federally funded programs are more likely to receive community-based training and, consequently, more likely to locate their practices in these areas.30 An analysis of the family medicine predoctoral training programs in the 126 allopathic medical schools in the nation revealed an important finding about the impact of federal funding on the propensity for undergraduates to choose family medicine residency training.37 Thirty-seven schools are considered "feeder" schools for family medicine because they send, on average, about 15% of their graduates to family practice residency programs. Of these schools, 29 (62%) require students to experience a family medicine clerkship in either their third or fourth year. These experiences are generally in ambulatory settings. In addition, 29 (78%) of the feeder schools received continuous federal support for predoctoral training in family medicine for 5 or more years, and an additional four schools received support for 3 years.

Fifteen schools had the least success in graduating physicians entering family medicine residency programs. On average, fewer than 5% of the graduates of these schools entered family practice residencies. Of these 15 schools, none had ever received a predoctoral training grant from the federal government, and none required a clerkship in family medicine.

Other studies demonstrate an association between community-based education and subsequent practice in similar settings.42

- Thirty percent of graduates of family practice programs are practicing in nonmetropolitan areas. Only 11% of physicians in other specialties are prac-
ticing in such areas.

- Students who take elective preceptorships are more likely to select a career in family practice and to practice in rural settings.
- Graduates of the primary care residency at the Montefiore inner-city residency program are more likely to practice in the inner city.
- Graduates of the University of Minnesota Rural Physician Associate Program, the Upper Peninsula Program of Michigan State University, and the Family Practice Residency Program at the University of Missouri-Columbia have higher rates of rural practice.
- The Washington/Alaska/Montana/Idaho program at the University of Washington has a rural focus, and its graduates are more likely to enter primary care and to practice in rural settings.
- North Carolina's Area Health Education Center Program has been successful in placing physicians in nonmetropolitan practices.

It appears that, without support for primary care ambulatory training experiences, the compelling financial incentives for students to enter other specialties will produce an even more rapid erosion in the number of students choosing primary care careers, impeding care for the underserved.

RECOMMENDATIONS

The following seven recommendations constitute a framework for long-term planning that is designed to (1) address the eroding primary care education infrastructure, through programs that promote enhanced recruitment, training, and retention of future physicians who are more likely to provide primary care and more likely to practice in underserved areas, and (2) produce an adequate supply of primary care physicians to practice in the most severely underserved areas, through programs that promote commitments to the NHSC and other service commitment programs.

1. Use the NHSC scholarship and loan repayment programs for the underserved areas that are hardest to staff. The NHSC plays an essential role in meeting long-term expectations to provide primary care physicians to underserved areas. The NHSC anticipates significant increases in the number of loan repayment agreements to support capacity expansion, and NHSC scholarships will eventually result in significantly higher numbers of primary care physicians available for placement in underserved areas. A service commitment component of a long-term plan is the most immediate means of moving primary care physicians into the most severely underserved areas.

2. Build postgraduate training and service linkages. Schools of medicine and community and migrant health centers and other sites for the delivery of primary care services need to work together to incorporate ambulatory training experiences in primary care education. Most academic institutions and ambulatory service delivery sites in underserved areas have not engaged in such linkages. Therefore, federal as well as state, local, and private support for primary care medical education should provide financial incentives that encourage institutions to work with appropriate entities providing primary care services for the underserved to incorporate ambulatory training experiences at those sites into the educational curriculum.

3. Redirect admissions criteria to students who are more likely to choose primary care careers and serve the underserved. Evidence indicates that the profiles of those entering medical school can have an effect on the numbers serving the underserved.4 Multiple studies demonstrate that physicians from rural backgrounds are more likely to select family practice as a specialty and to practice in rural settings.6 The under-representation of persons from racial/ethnic minorities among medical students and practicing graduates of US medical schools has been a concern for the past two decades. Admissions policies and inadequate or inappropriate secondary level preparation that leads to relatively high attrition after matriculation have been cited as causes of this persistent inequity. Admissions criteria should be redirected to include preference for students who will have a propensity to select a primary care specialty and rural practice—students from rural areas15,36-42 and minorities.16

4. Promote required third-year undergraduate medical clerkships in primary care. Students report their decision to specialize during their third year of undergraduate medical education.4 Studies show that preference for a career in family practice drops during the 4 years of medical school, while interest in the subspecialties increases dramatically. Curriculum time, number of faculty, perceived importance of the specialty, and presence of role models are among the institutional factors that influence career selection during undergraduate medical education.4 Therefore, it is essential that students be exposed to primary care practice in the ambulatory setting during the third year, before a career decision has been made.4 Federal as well as state, local, and private support for undergraduate medical education should be given preferentially to schools that require a third-year rotation in a primary care ambulatory setting.

5. Promote primary care research. To establish primary care as a scientific discipline, research activities in clinical patient care, primary care education, and health services research should be an integral part of the medical school research agenda. Federal, state, local, and private sources of funding for research conducted in medical schools and teaching hospitals should preferentially support the development of a coherent primary care research agenda. Medical effectiveness outcome research should continue to focus on primary care procedures and interventions to establish their efficacy and efficiency.

6. Train and develop community-based faculty. Curricular objectives and content in undergraduate medical education are determined by the faculty of each medical school. Few faculties have addressed the need for a balanced specialty and geographic distribution of physicians.43 Faculty in the academic setting, with their focus on advanced tertiary care, are uncertain or skeptical about the purposes of community-based education. They may perceive the quality of care and the quality of teaching at the academic center to be better than in the community. For primary care to flourish in medical education, serious efforts must be made to develop faculty with a commitment to changing the milieu of medical schools. Attracting students with a propensity for primary care, such as minority students, will require the development of minority faculty role models. In fact, curriculum change, service linkages, changes in admissions criteria, and even fiscal change will have to be preceded by faculty development. In their desire for quick fixes and solutions now, policymakers often overlook the first step—faculty development. Federal, state, and local support for primary care medical education should include programs for community-based faculty development.

7. Establish graduate medical education financing initiatives for primary care training. Although patient care delivery has shifted in the direction of outpatient settings, Medicare reimbursement for training does not provide sufficient incentives to support a shift in primary care training into those settings. Experts agree that the inpatient setting is no longer by itself an appropriate environment to train primary care physicians. Incentives must be developed for graduate medical education fi-
nancing to increase the amount of time primary care residents spend in ambulatory settings and to increase the number of training sites that resemble practice conditions likely to be experienced by primary care physicians in the future.

Medicare reimbursement funds should be used:

- To reward institutions that expand opportunities for primary care training. Direct and indirect medical education adjustments should provide incentives for institutions to develop service-education linkages and to reimburse resident training at outside sites.

- To provide individual incentives for medical school graduates to select careers in primary care. Direct and indirect medical education adjustments should be allocated to medical school graduates who select primary care careers. Resident bonuses, interest forgiveness, and loan forgiveness are among the substantial incentives that should be used to assist graduates with their looming indebtedness if they select primary care training and eventually practice in underserved areas.

- To support research and demonstration initiatives in primary care training. Support should be given through an allocation of Medicare graduate medical education reimbursement to a national pilot study of institutions and residents to test the efficacy of institutional rewards and individual resident incentives in support of primary care.

CONCLUSION

In the final analysis, unless there are substantial health improvements in certain populations that historically have been disadvantaged economically, educationally, and politically, not much progress will be made in the nation's overall health profile. Many Americans lack access to essential primary care. Among the barriers to access is the low number of primary care physicians. Although reversing the trend in specialty selection of medical students encompasses many factors, education is one part of the solution. Strategies for improving primary care education must include changes in admission criteria, promote service-linked training, restructure the clerkships required in the third year of medical school, develop faculty to alter the educational milieu, and provide incentives for graduate medical education financing of primary care. All entities that underwrite medical education should accept the responsibility to assist in improving the health of the underserved and to ensure access to primary care physicians.

References


