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TITLE: PRIMARY CARE PHYSICIANS AND VULNERABLE POPULATIONS: A CROSS-SECTIONAL ANALYSIS

PRESENTATION TYPE: Single 15 minute presentation

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ABSTRACT BODY:

Abstract Body: Purpose. Primary care access barriers persist in the US and affect the poor and uninsured (1). Research has shown that international medical graduates (IMGs) have made substantial contributions to the primary care workforce (2). The purpose of the current study is to compare the distribution of physicians providing patient care in the United States in 2010 and 2015, and identify change in the distribution based on physician type [MD, DO, IMG, US citizen IMG (US-IMG)].

Method. A cross-sectional descriptive analysis was conducted using data on major professional activity and self-reported specialty from the 2011 (2010 data) (3) and 2016 (2015 data) (4) AMA Physician Masterfiles. These files were merged with ECFMG's biographic and educational data for IMGs, to identify country of medical school and citizenship at the start of medical school. Each dataset was matched to the 2010-2011 (5) and 2015-16 (6) Area Resource File. Physicians who were non-federal, provided direct patient care, and who reported their specialty as general or family practice, general internal medicine, geriatric medicine, pediatrics, or obstetrics and gynecology, and were age 65 or younger were included in the current investigation. Descriptions of physicians by type (MD, DO, IMG, US-IMG) for each cohort (2010 vs. 2015) are provided. The Area Resource File was used to determine the extent to which physicians provided care to those who have low levels of education and employment, and are uninsured.

Key findings. Based on the 2011 Masterfile, 239,017 physicians provided direct patient care in the specialties listed and were age 65 or younger; in contrast, 217,460 physicians had these characteristics in the 2016 Masterfile. Comparing 2010 and 2015 data, there were slight declines in the number of physicians reporting primary care specialties, though the percentages by physician type were stable: MDs: n=149,721 (63% of all primary care physicians) vs. n=133,063 (61%); DOs: n=22,737 (10%) vs. n=21,895 (10%); IMGs: n=50,739 (21%) vs. n=46,188 (21%); and US-IMGs: n=15,820 (7%) vs. n=16,314 (8%); in 2010 and 2015 respectively. In comparing the two cohorts, internationally trained physicians were more likely to serve those classified as 'low education': 11% of IMGs in 2010 (n= 7,347) and 2015 (n=7,132) vs. 7% of US trained physicians in 2010 (n=11,397) and 8% in 2015 (n=12,554). There was an increase in the percentage of US trained physicians located in areas of 'low employment': 7% of US trained physicians in 2010 (n=6,873) and 8% in 2015 (n=9,632), while the percentage of IMGs was slightly lower: 8% of IMGs in 2010 (n= 5,064) and 7% in 2015 (n=4,331). Finally, there was an increase in physicians providing care to the uninsured: 16% of US trained physicians in 2010 (n=27,996) and 18% in 2015 (n=27,359), though the IMG percentage remained higher: 20% of IMGs in 2010 (n= 13,570) and 22% in 2015 (n=13,796).

Implications. Graduates of international medical schools who are in primary care specialties tend to serve vulnerable populations. In determining approaches to meet projected physician workforce needs, it is important to consider that international medical graduates play a vital role in ensuring adequate care for the most vulnerable populations.

References

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