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**AAMC Press Teleconference  
Release of the 2020 Workforce Projections Report**

**Friday, June 26, 2020  
10:30 a.m. ET**

**Participants:**

David J. Skorton, MD, AAMC president and CEO  
Janis Orłowski, MD, AAMC chief health care officer  
Karen Fisher, JD, AAMC chief public policy officer  
Michael Dill, MPA, AAMC director of workforce studies  
Sherese Johnson, MPH, AAMC director of public health initiatives  
Karey Sutton, PhD, AAMC director of health equity research

**MODERATOR:** Welcome, everyone. The online conference is about to begin. Please note today's call is being recorded. Please stand by. The Association of American Medical Colleges is pleased to welcome you to today's press conference, AAMC's release of the 2020 Physician Workforce Projection Report.

My name is Sandy, and it is my pleasure to be the facilitator for today's event. Please note today's call is being recorded. When you want to ask a question, press star 1 on your telephone keypad to be placed into the phone queue. You will still be able to hear the presentation while you are waiting. When the speakers are ready to take your question, your line will be unmuted. Please announce yourself with your name and media outlet.

And now I would like to introduce Dr. David Skorton, President and CEO of the AAMC. Dr. Skorton?

**David Skorton, MD:** Thank you very much, Sandy, and welcome, everyone. Thank you for joining us at today's media briefing to reveal the latest data on the projected shortage of U.S. physicians.

As the head of an organization whose mission is to lead and serve America's academic medical centers to improve the health of people everywhere, I believe these data we will share with you momentarily -- which continue to show a significant physician shortage in our country over the coming decade -- should be of grave concern for us all.

Over the last few months as our nation has battled coronavirus, we have seen in stark detail how fragile and quickly overwhelmed America's health care system truly is; and we're nowhere out of the woods of this public health emergency yet. In fact, we're still in what is considered the first

wave of this massive pandemic. If you've joined us for one of these briefings over the past several weeks, you know that the AAMC member medical schools, teaching hospitals, health systems, and academic societies have been and are on the front lines during this pandemic and have seen firsthand the impact the pandemic has had on our health care workforce and shortages that have occurred in hot spots around the nation.

Our members include teaching hospitals in rural areas such as Dartmouth-Hitchcock Medical Center in New Hampshire, as well as many urban areas including -- just as examples, Mass General in Boston, Georgetown University Hospital here in the District of Columbia, and the University of California-Davis Medical Center in Sacramento. The challenges our members and the nation at large are facing are significant.

Let me briefly share some figures from the AAMC's sixth annual study on physician supply and demand, which we're releasing today. We're projecting that the United States could see an estimated shortage of somewhere between 54,000 and 139,000 physicians by the year 2033. That is including importantly shortfalls in both primary and specialty care. Yes, that's tens of thousands of physicians we'll need but will not have available to us.

The persistent shortage means people across America will have ongoing difficulty accessing the care that they need, especially as we all age. Whether it's a primary care physician, a general surgeon, a neurologist, a cardiologist, or a psychiatrist -- specialty physicians shortages, especially those based in a hospital setting including critical care, emergency medicine, infectious disease and pulmonary specialist are particularly urgent amid a pandemic.

In addition, we have too many patients falling through the gaps in our current system because they don't have insurance; because they live in poverty; or because they live in a community that does not have access to doctors or a hospital. And we know if under-served populations were able to access the health care system more at similar levels as those who don't have access barriers, then current demand could rise by an additional 74,000 to 145,000 physicians.

Now, solving this major challenge will require multiple efforts, but we must start by ensuring we're training enough future doctors to feed the workforce pipeline to meet the demand not only now but for generations to come. To ensure access to care, one essential step that we believe Congress must take is to end the freeze that has been in place since 1997 that limits federal support for residency training of new physicians. That's why we strongly support the bipartisan Resident Physician Shortage Reduction Act of 2019, introduced in Congress to provide increased Medicare support for an additional 3,000 new residency positions each year over the next five years. That's a good start, but there will be other steps we need to take, too, including enabling advanced practice nurses and physician assistants to play a greater role to increase the overall capacity of the larger health care workforce.

During the question-and-answer, I will ask my colleague Karen Fisher, who's the AAMC's chief public policy officer, to discuss some additional policy actions that we believe are essential to

increasing access to care. No matter what policies we enact, we know they should be grounded in evidence and data.

On that note, I would like to turn it over to my colleague, Dr. Janis Orlowski. Dr. Orlowski is the chief health care officer at the AAMC, a practicing physician and national leader, and she will share the key findings for the AAMC updated physician workforce report. Janis, over to you

**Janis Orlowski, MD:** Thanks very much, Dr. Skorton, and good morning, everyone. Thank you so much for joining us.

As Dr. Skorton mentioned, this is the sixth annual study conducted for the AAMC by IHS Markit, a global information company that works on big data and data analytics, and they have used a methodology, looking at all U.S. citizens and health care data, to develop trends, norms of utilization of physician sources.

We work with many people to develop scenarios to -- for IHS to analyze so we take a look at scenarios such as looking at increases in managed care; more care by nurse practitioners and physician assistants. And then we look at supply scenarios -- how many hours do physicians work? When are physicians going to retire? Will they retire early? Will they retire late? Combining and studying these multiple and different scenarios, we project there will be an overall physician shortage over the next decade through 2033 of 54,000 to 139,000 physicians.

Why is this important for us to study? I think we can understand by looking at what is happening now with the pandemic, and what has happened over the last year. The health care community, working with local, state, and federal officials must plan for the future. Just as we determined how many schools we must have in a specific area, what the transportation needs are for public transportation and for roads, we must also plan for our physician work force. You can see the system is stressed now when we don't have sufficient physicians for rural areas. For example, the issue of increased maternal morbidity partially has been linked to the lack of access of adequate physicians.

We can also see this when we don't have sufficient position who are behavioral health specialists for the opioid epidemic and today, we see governors calling for retired physicians or physicians from other states to come help battle the pandemic within their states right now. So there is a need not just for primary care physician but for critical care doctors; infectious disease doctors; emergency room doctors.

This year, we also completed a national sample survey of physicians across the United States. This survey data provides an update to all of this physician-specific data within the study. We looked at the number of hours that physicians are working; we looked at the technology that they use in their practices; and we also ask them about plans for retirement.

Why is there a shortage? There are two main reasons why there's a shortage.

First of all, there's a growing U.S. population, and we know between now and 2033 it's estimated the U.S. population will rise by 10.5%. We also know with the aging U.S. population, 10,000 people a day turning 65, that the aging population uses more physician services.

We also know that in the next decade two out of five currently active physicians will be older than 65 so we're looking at their ability and desire to continue to practice and what their retirement needs will be.

Finally, I want to turn your attention to the section within the report that discusses equity of utilization of physician services. Not all people can access doctors equally. There are problems in access in rural areas; there are problems with individuals who are not insured or not insured adequately, that they do not have equal utilization. And most disturbingly is the inequity of access we see to people of color. There's structural racism within the health care system that must be addressed.

So if everyone had the same health care access and the same utilization rates, regardless of where they live -- and what health insurance they would have -- today we would need 74,100 more physicians.

If we had the same access regardless of where someone lived, their insurance status, and their race, we would need 145,500 more physicians to have equal utilization. This report is important not just for city planners, state governors, and federal government; but it's important for the public to understand and help to prepare for the future. Dr. Skorton, back to you.

**David Skorton, MD:** Thanks so much, Dr. Orłowski, for that explanation; for all you did with your colleagues to bring this study to fruition. Well now, we're ready to shift by the question and answer portion where we will be joined by a few additional colleagues from the AAMC leadership. If there are questions we don't get time to answer or you think of something later on, please send them to us by e-mail to [press@AAMC.org](mailto:press@AAMC.org). Thank you. Sandy, we're ready for questions.

**MODERATOR:** Excellent. Thanks so much, Dr. Skorton. Just as a reminder, all you need to do is press star 1 on your telephone key pad to be placed into the phone queue. You will still be able to hear the presentation while you're waiting. So when the speakers are ready to take your question, your line will be unmuted. Please do announce yourself with your name and media outlet so we can identify you. And the questions will be answered in the order we receive them. At this moment we have not received any questions over the phone yet, but I will keep you updated.

**David Skorton, MD:** Thank you, Sandy. You can signal me when that happens. In the meantime. I wonder if Karen Fisher, our chief public policy officer, would like to offer any more thoughts about policy of ideas that she and her colleagues have beyond the increase in residency slots that I mentioned. Karen, over to you.

**Karen Fisher, JD:** Right. Thank you, David.

Let me start by building on the discussion about the resident physician shortage act that you mentioned. As a reminder, only 20% of hospitals in this country train physician residents and other health professionals. That's because it's a critical mission and there're additional costs associated with doing that training.

The AAMC member teaching hospital and medical schools comprise only 5% of the total hospitals in the country but are responsible for training 75% of the residents in this country. So the mission, particularly for academic medical centers, is very key.

As David mentioned, Medicare, since 1965, has recognized that there are costs associated with training and said that they would help offset some of those costs by virtue of the Medicare programs.

As David mentioned, in 1997, that support was frozen; and the Physician Shortage Reduction Act introduced by bipartisan members in both the House and Senate would help responsibly ease some of that task by adding 15,000 residency slots over the next five years.

But there are also other federal policy programs that help address the workforce program, including some of the programs run out of the Health Resources and Services Administration, the HRSA, so-called Title VII programs which increase the supply, distribution, and diversity of the health care workforce. And those programs reach over 400,000 participants. Those programs are funded annually by the federal government and are in critical programs to help address both the supply but also the distribution and the access of physicians to vulnerable areas.

I would also point out that there are programs such as the children's GME program, teaching health centers, etc., that help with residency training.

And then I would mention that as people have seen, particularly in the last several months -- and we have seen with our academic medical centers -- the use of telehealth to be able to expand access. And the federal government has been very supportive and in providing waivers to be able to allow hospitals and physicians and particularly our teaching hospital and teaching physicians, to expand their access through telehealth mechanisms. We think the telehealth mechanism is an excellent mechanism that has been used through covid but can also be used in ordinary times beyond Covid and should be an important access mechanism and think the federal government has an important opportunity to be able to continue to expand those waivers; make permanent those waivers to allow that access to continue.

So that's just a couple of ideas, David, we have been working on.

**David Skorton, MD:** Thanks very very much, Karen. Sandy, any other questions so far in the queue?

**MODERATOR:** No, we don't have anybody with a question at this point.

**David Skorton, MD:** Okay. Then I want to follow up on one other thing to make sure we cover it while people are, perhaps, formulating questions; and before I do, I just want to mention to members of the media that we're very glad to take questions on any aspect of what is happening in our country right now related to health, including the pandemic and anything related to health equity, which is so much on everyone's mind.

On that latter topic, I wonder, Dr. Orłowski, if you can give us your thoughts to expand on the comments we had in the opening remarks that indicate that should we come to a point in this country where those who currently do not have access to health care do, in fact, have access and insurance coverage; that the shortage would be exacerbated even more. Give us some further thoughts on that if you would, Dr. Orłowski.

**Janis Orłowski, MD:** Absolutely. So one of the things we try to study over the last couple of years was to take a look at who is not able to get access to physicians; and we were trying to decide, is this a -- did they not have access because they didn't have insurance? Did they not have access because there was no one locally? Or did they not have access for other reasons?

So we have done consumer surveys over the last many years, and we continue to ask the public why they do not have access. In a number of situations, they say, quite frankly, they're unable to get access because of insurance issues.

Secondly, they have told us that they have not been able to see a physician because there's no one that is in their local area.

And as a personal story, my parents moved from the Chicago suburbs -- they have a second home in Northern Wisconsin, where they're spending more time. I would say I'm a very knowledgeable person of health care across the United States, and it took nearly a year before I was able to find a primary care physician who would see my parents up in rural Wisconsin. So there are these continual access issues in rural America.

Finally, we took a look at substantial differences in utilization in people of color, and I know as we take a look at this there has been a discussion that different cultures seek medical care for different reasons. I believe, though, if you look at the data, it's very clear there are structural inequalities in being able to access care and that people of color find it more difficult to find a physician and to have regular access to a physician.

And as I said, those numbers -- if you take a look at rural -- if you take a look at insurance -- and if you take a look at attempts to equalize access; we would actually need 150,000 physicians today to equalize the disparity we see in access.

We talked today about the fact that there are differences in how long a person lives from county to county so, for example. For example, I was speaking to colleagues at BJC in St. Louis, and they notice as they take a look at counties, Ferguson has a life span on average that is about 20 years less than the neighboring county. And as they take a look at those disparities, there's a number of factors. It's really access for chronic illnesses that makes the difference. Is blood pressure treated adequately? Is hypertension treated adequately?

So this access to care, along with many factors, explains some of the tremendous differences that we're seeing; and quite frankly, these are issues that we must address as we address other issues of racism within our culture.

**David Skorton, MD:** Thanks very, very much. Sandy, I understand we do have some questions from the press now.

**MODERATOR:** Yes, we do. The first question, Dr. Skorton, is from Marcia Frellick with Medscape news. Marcia?

**REPORTER:** So this report projects moderate increase in use of advanced practice providers. Why do you say only moderate and what kind of numbers are we looking at there?

**David Skorton, MD:** Janis, do you want to start with that one? And then you can ask your colleagues to pitch in if you like.

**Janis Orlowski:** Sure -- would be happy to. So, actually, if you take a look at the report, we have two different scenarios. We have a moderate, and we have a high scenario for the use of PAs and nurse practitioners.

What we take a look at is we have taken a look at the literature and we take a look at for many different factors -- I'll just give you one example, and it's panel size. We have taken a look at the panel size of nurse practitioners and physician assistants versus physicians; and we find that the panel size is smaller. It's still a robust panel size, but it's smaller. So we have looked at that, and that's why we have a moderate nurse practitioner and PA

We believe that there's going to be continued growth and I'm going to turn this over to my colleague Michael Dill, who's director of the Workforce Unit who will talk about some of the newer data that we're looking at. Michael?

**Michael Dill, MPA:** Thanks, Janis. Yes, so, as you said, you know, we have always included two different scenarios for the effect that advanced practice nurses and PAs might have on easing the demand for physicians -- both the moderate and the high impact scenarios. But there's been a dearth of data on, sort of the effect that the growing supply of PA and advanced practice nurses will have on meeting the demand for services so we did two new analyses that we included in -- analysis we included in this year's report.

One is an analysis of CDC data, admittedly, is based on visits to emergency departments but divides visits by whether or not a PA or APRN advanced practitioner were seen. And so, we were able to take those data, and applied them across all specialties and settings just to look at what effect the trends we're seeing and those data would have if we used that as a scenario. The results were similar to the high scenario were already include.

Then we also included -- we also looked at another scenario where we looked at a significant impact on meeting the need for primary care specifically, due to the growth and the number of advanced practiced nurses and PAs and again found the results were similar to the high scenario that we already had, although with more of an impact of primary care since that's what we were looking at.

**REPORTER:** Thanks very much.

**Michael Dill, MPA:** Thank you.

**David Skorton, MD:** That was Michael Dill, director of Workforce Studies at the AAMC. Sandy, we're ready for the next question.

**MODERATOR:** Okay, thank you. The next question is from Ginger Crist at Modern Healthcare.

**REPORTER:** Hi, there. So thank you all for this. I'm curious about given the shortages that are predicted, how do you see that playing into some of these changes we're seeing with physician compensation and things like that have happened throughout the pandemic? How do you see those two things kind of correlating, you know, as we're seeing all of these potentially temporary solutions and actions being made, you know, as we move forward and try to address this shortage?

**David Skorton, MD:** This is -- thank you very much for the question. This analysis was based on data a bit before the pandemic struck, but I know that Dr. Orlowski will have some observations, even though the data were collected a little bit ahead of the pandemic. Janis, any comments on this question?

**Janis Orlowski, MD:** Sure, and thanks for the question, Ginger; and before I answer it, I want to go back. I used a term in my last answer and that was "panel size," and that might be an inside baseball term so I just want to make sure I defined it. So panel size means --  
(no audio)

**David Skorton, MD:** You still there, Dr. Orlowski?

**Janis Orlowski, MD:** I'm sorry. Panel size refers to the number of active patients that a physician follows; and so we tend to use the word "Panel size" with primary care physicians

following between 1500 and, say 2,000 -- maybe a little bit more than 2,000 as an active panel size.

The second thing in regards to your question -- which is payment -- I think, Ginger, there is an acute change in the economics of health care systems and physician offices today; and that acute change has to do with the not seeing elective cases and not doing procedures and switching to the care for the pandemic. So I think that the change we're seeing in physician salaries is a point in time right now. It may, though, take us two to three years to recover from this financial impact; and so the -- it's a great question because I think that we're going to see a continued demand for a physician services and then a recovery from the financial impact. So, you know, that's what I see over the next -- not just months but next couple of years.

**David Skorton, MD:** Great. Thank you very much, Dr. Orlowski, and thank you for that question, Ginger. Sandy, we're ready for the next question.

**MODERATOR:** At this point, Dr. Skorton, we do not have any other questions.

**David Skorton, MD:** Okay. Then I might ask if either Sherese Johnson or Karey Sutton would like to comment on any of the questions and things we're bringing up related to health equity on the tail of Dr. Orlowski's comments about that since that is such an enormous issue and has been for a long time. Sherese is the Director of public health initiatives at the AAMC; and Dr. Karey Sutton is Director of health equity research. Any thoughts you would like to share with the media?

**Sherese Johnson:** Sure, David. One thing I might add to the conversation as it relates to increasing representation of physicians within the workforce is the fact that we have to be cognizant and also take action upon increasing the diversity of the workforce; and by doing that, we know from previous data studies and evidence that minority physicians are more likely to practice in underserved areas and to work with minority communities that represent their racial and ethnic backgrounds, which is important from a health and health care disparity standpoint because they're more likely to be involved in addressing these issues. And so it's beyond improving access but also understanding the communities in which our physicians represent and their patient populations and what they represent from a culturally competent standpoint and ensuring that our health professions workforce is not only diverse but they're also prepared from understanding the belief, origins, backgrounds, and different issues that are part of the communities in which we want to increase equity, access, and build trust within those communities; and also improve their patient experience, quality, and satisfaction with the health care system.

To do that, we need to really be cognizant of how we increase equitable access early on in the educational pipeline so not just waiting until students get to college or involved in graduate studies but really being sure that we address how we have resources for our elementary students; middle school students; high school students; etc., and their exposure to the health care careers.

**David Skorton, MD:** Thank very much, Sherese. Karey, any comments you would like to add on this issue or anything related?

**Karey Sutton, PhD:** Yes, Dr. Skorton, thank you. I would like to expound upon a point Dr. Orłowski was making about increasing access and looking at utilization pattern. One thing we do note is because of those things she mentioned, access does not always equal increase utilization and increased utilization does not always equal high quality care. Many of these things are rooted in racism so in order for us to achieve the state of health equity where everyone is able to attain those opportunities to achieve that best health, we must be able to address racism, which creates these injustice and inequities in health.

**David Skorton, MD:** Thanks very, very much, Dr. Sutton. Sandy, any more questions in the queue?

**MODERATOR:** At this point, we do not have any more questions.

**David Skorton, MD:** Okay, thank you. Well, then, we're going to wrap up the press conference so I want to thank everyone in the media for coming. If you'll permit me, I want to thank you for the great coverage you're doing day today with all the incredible challenges we're dealing in this country right now; and I want to remind you should you have a question you didn't have a chance to ask, please write to us at [press@AAMC.org](mailto:press@AAMC.org), and we'll get right back to you. Thank you very, very much for participating. Thanks to all the speakers and respondents. Sandy, turning it back to you.

**MODERATOR:** Very good. Thanks so much. So with that, we will conclude today's program. This session has been recorded, and AAMC Media Relations will post the link to the recording on the AAMC website this afternoon. On behalf of the Association of American Medical Colleges, thank you and have a great day. You may now disconnect.

**End of Press Conference**