COMMENTARY

Why Are Family Physicians' Panels Shrinking?

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The average panel for family physicians dropped from about 2400 to about 1800 patients from 2013 to 2022. Likely reasons for this decline: 1) fewer people seeking primary care, and 2) fewer people receiving their care through a long-term continuity relationship with a primary care clinician. (J Am Board Fam Med 2024;37:502–503.)

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Bazemore et al. report an astonishing finding in their policy brief "Self-reported panel size among family physicians declined by over 25% over a decade (2013 to 2022).[1]" For family physicians able to estimate their panel size, the average panel dropped from about 2,400 to about 1,800 patients over those 10 years. Panel size represents the number of patients a primary care physician is responsible to care for.

From the point of view of clinicians and patients, smaller panels might seem like a relief.

Physicians with large panels tend to shorten visit times to handle the constant patient demand. Excessive panel size is associated with clinician stress, burnout, and intent to leave practice. For patients, access to primary care goes down as panel size goes up. As visit times go down, patient satisfaction drops and preventive services decline.[2] Perhaps the 25% average panel size reduction is a positive development.

But let us take a population health perspective. Every person in the United States should have a primary care clinician with whom they build a trusting relationship. One hundred family doctors with an average panel size of 2,400 would be caring for 240,000 patients. With the lower panel size of 1,800, these 100 physicians would be caring for only 180,000. On a national level, millions more people would be unable to find a primary care clinician at the lower average panel size. Rather than a step forward, the panel size reduction is a warning sign, signifying that primary care has less capacity to care for the people of this nation.

The panel size drop comes on top of a reduction in the number of per capita primary care clinicians (physicians, nurse practitioners and physician assistants). Since 2014, the number of primary care clinicians per 100,000 individuals has steadily fallen. The retirement of primary care physicians (PCPs) far exceeds the entrance of these physicians into the primary care workforce. These changes are evidenced by multiple anecdotes of patients being unable to find a primary care practice open to new patients and having trouble getting prompt primary care appointments. By 2025, the United States will have a projected shortage of about 52,000 PCPs.[3] 2025 is next year!

Why might panel size be shrinking? Many people have stopped going to primary care altogether. In 2019, Chou et al. reported that primary care office visits per capita for acute care dropped 32% from 2002 to 2015.[4] According to Ganguli et al., primary care visits for commercially insured adults dropped by 24% from 2008 to 2016, and the proportion of adults with no primary care visits in a year rose from 38% to 46%.[5] Primary care visits are going down because poor access diverts patients, especially those in younger age groups, to retail clinics and urgent care centers. Two to three thousand retail clinics – many in drug store chains – exist in the US. The number of urgent care centers grew from 6,400 in 2014 to more than 9,000 in 2020. In 2019, nearly 3 in 10 adults visited a retail clinic or urgent care center. Another factor discouraging patients from seeking primary care is the growing prevalence of high-deductible health plans, which may require patients to pay up to $5,000 per year before the insurance kicks in, making primary care out of reach for many in the United States.

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See Related Article on Page 504.

Not only are fewer patients seeking primary care; in addition, people coming to primary care may no longer be members of any clinician's panel. In 2014, 22% of the US population had no usual source of health care. For 44%, the usual source of care was a facility rather than a personal clinician, with only 15% having a personal clinician as their usual source of care. From 1996 to 2014, the proportion of people with no usual source of care, and with a facility as the usual source, increased. The proportion with a specific clinician as the usual source of care dropped by 43%.[6] The 44% who designate their usual source of care as a facility are likely receiving care from several clinicians in the facility, and thus are unlikely to appear on any clinician's panel. When I was in primary care community practice, some patients were listed on my panel while others saw me 1 week and 1 of my partners the next week. This population continues to use primary care but sees several different clinicians and is not empaneled.

In summary, the dramatic panel size reduction is likely an effect of 1) fewer people seeking primary care, and 2) fewer people being listed on any clinician's panel.

It is important to note that the panel size reduction described by Bazemore et al.[1] is limited to family physicians. An increasing proportion of primary care visits are with nurse practitioners (NPs) and physician assistants (PAs). NP/PAs may have their own panels or may see patients who are unempaneled or empaneled to a physician. Making up one quarter of all primary care clinicians in 2016,[7] NP/PAs are providing enormous support to primary care as the number of primary care physicians falters.

Does the reduction in panel size reduce clinician work? It is unlikely that the amount of work is dropping. Clinicians are seeing patients on their panel plus unempaneled patients. In addition, primary care visits are more challenging as the US population ages, with a 39% 10-year increase in the number of people older than 65. A panel of 1800 patients may take as much clinician time as a panel of 2,400 in years past. Moreover, panel size is a crude metric and requires adjustment based on patient illness burden, the strength or weakness of a team that could help care for a panel, and whether or not the clinician practices comprehensive primary care or refers many patients to specialists.

The 25% decline in self-reported panel size among family physicians overestimates the reduction in primary care utilization for the US population. Only a portion of the panel size reduction seems to be a drop in primary care visits; another major factor is the shift in patients' usual source of care from individual clinicians to facilities. With the growth in size of primary care practice size, patients viewing the practice, rather than the clinician, as their care provider may schedule visits with a number of different clinicians. These patients would generally not appear on any clinician's panel, thus accounting for a significant portion of the 25% panel size reduction.

Sustained, personal relationships between patients, their families, and their primary care team improves patient outcomes and reduces unnecessary utilization of emergency rooms and hospitals.[8] We are faced with both the reduced use of primary care and the shift to the facility – rather than the clinician – as the usual source of primary care. The most significant casualty of these developments may be the waning of the long-term trusting relationship between patient and clinician.

To see this article online, please go to: http://jabfm.org/content/37/3/502.full.

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