EDITORIAL

PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

A Different Lens on the Primary Care Workforce Shortage—Who Is Accepting New Patients?

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Primary care has many benefits for individuals, communities, and the health care system.[1] Patients with regular access to primary care have better overall health,[1] regions with higher primary care physician to population ratios have lower all-cause and disease-specific mortality,[2] and the supply of primary care clinicians is inversely associated with total health care spending.[3] Yet, the share of US adults who do not have a usual source of primary care has grown by more than 20% in the last decade.[4] Projections suggest that the supply of primary care clinicians is not increasing fast enough to meet the demands of the aging population in the US.[4]

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Just how difficult is it for people in the US without a primary care clinician to find one? In this issue of *JAMA Internal Medicine*, Morgan et al[5] aim to better characterize this challenge by counting the primary care clinicians (primary care physicians [PCPs] and advanced practice clinicians [APCs; ie, nurse practitioners and physician assistants]) who are likely to be accepting new patients. Specifically, the authors used fee-for-service Medicare claims data to identify primary care clinicians who billed for more than 11 new patient visits annually. By this measure, which provides a more nuanced view into primary care access beyond the number of clinicians per capita, the authors[5] found that the number of primary care clinicians available for new visits decreased from 23.4 to 22.2 per 100 000 Medicare beneficiaries from 2013 to 2021. While the number of APCs available for new visits increased 91.4% during the same period, this growth did not offset the 24.9% decrease in available PCPs.

The reasons underlying these findings are varied and intertwined.[6] The decline in new patient access reflects the reality that fewer physicians are entering primary care; fewer than 1 in 10 graduates from internal medicine residency programs now pursue a career in primary care.[6] Meanwhile, due to factors such as burnout,[7] many currently practicing PCPs are reducing their clinical hours or leaving the field entirely.[8] Whereas some have posited that primary care APCs may compensate for the decline in PCPs, the study by Morgan et al[5] suggests otherwise, likely because APCs are subject to the same financial and work condition incentives as physicians and are increasingly choosing to work in subspecialty settings.[6] Underlying these trends is the reality that the work of primary care has become harder. The aging US population is more medically complex,[9] and advances in diagnostics and therapeutics require extra time to consider and discuss with patients. There is also the growing use of asynchronous communication[10] and administrative burdens, such as prior authorizations and documentation requirements, that consume clinicians' time.[6] Finally, primary care payment models have not evolved to support the additional requirements and changing nature of the job, creating a vicious cycle: diminished supply in the face of growing demand stretches the remaining clinicians even further, undermining their ability to provide, and diminishing the joys of practicing, high-quality primary care.

To address the urgent workforce challenges buffeting primary care, we need an all-of-the-above strategy.[6] First, pedagogical and structural changes to medical education can aim to increase the supply of primary care clinicians. Reforms could include curricula that incorporate earlier primary care experiences, community-based primary care training programs,[11] reduced length of medical school,[12] free tuition, and loan forgiveness programs. Graduating medical students face entrenched long-term financial disincentives (which the new federal loan limits enacted as part of the One Big Beautiful Bill Act are likely to exacerbate[13]) that discourage entering primary care. Free medical school tuition alone does not reliably draw students to primary care[14]; therefore, making tuition relief contingent on primary care commitments may be necessary. Reducing training costs for PCPs may also make it easier for individuals from disadvantaged backgrounds to choose this career path and encourage clinicians to practice in underserved areas that have the lowest access to primary care. Additionally, immigration restrictions should be lifted for non-US-born trainees who are more likely to enter primary care[15] and work in medically underserved urban and rural areas.[16]

Second, payment reform is critical to improving access to primary care. Payment reforms should target greater parity with subspecialty procedural disciplines and ensure that primary care clinicians earn compensation that is commensurate to their work and the value they provide.[17] The US Centers for Medicare & Medicaid Services' 2025 introduction of Advanced Primary Care Management Services (APCM)[18] represents a promising step in the right direction. APCM billing codes are stratified by patient complexity, require minimal documentation, and provide clinicians with predictable and flexible monthly payments to support previously uncompensated between-visit work and the work of nonphysician team members.

Changes to how, and how much, primary care clinicians are paid will enable health systems make the job more sustainable. For example, health systems can hire, train, and make full use of all members of the interprofessional care team (eg, PCPs, APCs, nurses, pharmacists, social workers, and case managers). The thoughtful application of established (eg, telehealth) and emerging (eg, artificial intelligence) technology might reduce burnout while improving workforce retention and recruitment.

The study by Morgan et al[5] illuminates the complex state of primary care. Their results suggest that APCs will be an important, but likely inadequate, means of increasing access to primary care. An important limitation of this study was that it only looked at fee-for-service Medicare patients; more research is needed to understand primary care access in other populations and what policy interventions will be effective in areas with especially marked shortages. Despite considerable systemic and demographic challenges, there are reasons for optimism. With time, training and payment reforms can allow clinicians to get back to what they do best: providing comprehensive, longitudinal, patient-centered, and high-quality primary care.

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REFERENCES

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x

2. Shi L. Primary care, specialty care, and life chances. *Int J Health Serv*. 1994;24(3):431-458. doi:10.2190/BDUU-J0JD-BVEX-N90B

3. Franks P, Fiscella K. Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience. *J Fam Pract*. 1998;47(2):105-109.

4. Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The health of US primary care: 2024 scorecard report—no one can see you now. Accessed November 11 2025. https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

5. Morgan KM, Karadakic R, Barnett ML. Primary care clinicians available for new patient visits. *JAMA Intern Med*. Published online January 20, 2026. doi:10.1001/jamainternmed.2025.7465

6. National Academies of Sciences, Engineering, and Medicine. *Building a Workforce to Develop and Sustain Interprofessional Primary Care Teams*. The National Academies Press;2025. doi:10.17226/29226.

7. Agarwal SD, Pabo E, Rozenblum R, Sherritt KM. Professional dissonance and burnout in primary care: a qualitative study. *JAMA Intern Med*. 2020;180(3):395-401. doi:10.1001/jamainternmed.2019.6326

8. Neprash HT, Chernew ME. Trends in physician exit from fee-for-service Medicare. *JAMA Health Forum*. 2025;6(7):e252267. doi:10.1001/jamahealthforum.2025.2267

9. Maresova P, Javanmardi E, Barakovic S, et al. Consequences of chronic diseases and other limitations associated with old age—a scoping review. *BMC Public Health*. 2019;19(1):1431. doi:10.1186/s12889-019-7762-5

10. Willard-Grace R, Knox M, Huang B, Hammer H, Kivlahan C, Grumbach K. Burnout and health care workforce turnover. *Ann Fam Med*. 2019;17(1):36-41. doi:10.1370/afm.2338

11. Hawes EM, Adhikari M, Rains J, et al. Evaluating teaching health center planning and development: unlocking and sustaining the full potential of the teaching health center program. *J Grad Med Educ*. 2025;17(3):296-303. doi:10.4300/JGME-D-24-00593.1

12. Emanuel EJ, Kim EK. Make medical school three years. Accessed November 12, 2025. https://www.nytimes.com/2025/11/10/opinion/medical-school-three-years.html

13. US Congress. One Big Beautiful Bill Act, HR 1, 119th Cong (2025). Accessed November 17, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1/text

14. Emanuel EJ, Guido M. Free med school tuition won't solve the shortage of primary care physicians. Accessed October 28, 2025. https://www.statnews.com/2024/04/22/free-medical-school-tuition-primary-care-doctor-shortage

15. Ahmed AA, Hwang WT, Thomas CR Jr, Deville C Jr. International medical graduates in the US physician workforce and graduate medical education: current and historical trends. *J Grad Med Educ*. 2018;10(2):214-218. doi:10.4300/JGME-D-17-00580.1

16. Commodore-Mensah Y, DePriest K, Samuel LJ, Hanson G, D'Aoust R, Slade EP. Prevalence and characteristics of non–US-born and US-born health care professionals, 2010-2018. *JAMA Netw Open*. 2021;4(4):e218396. doi:10.1001/jamanetworkopen.2021.8396

17. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Improving Primary Care Valuation Decisions for the Physician Fee Schedule by the Center for Medicare. *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule*. Meisnere M, Ganguli I, Bitton A, eds. National Academies Press; 2025.

18. US Centers for Medicare & Medicaid Services. Advanced primary care management services. Accessed October 28, 2025. https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services