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AFMRD Association of Family Medicine Residency Directors

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INFLATION OF FAMILY MEDICINE RESIDENCY APPLICATIONS

Last year, graduates from MD-granting medical schools in the United States applied to an average of 23.7 family medicine residency programs and interviewed at 11. This year, applications were projected to increase again to 25.8[1] (a 57% increase since 2009). During this same time period, allopathic family medicine graduate medical education (GME) positions offered through the National Resident Matching Program (NRMP) have increased 18% from 2,730 positions in 2011 to 3,216 positions in 2015; fewer than one-half of these positions were filled by US MD seniors.[2]

The increased applications per residency slot are creating a burden on residency programs as they strive to adequately review applicants. This congestion in the application review process may also lead to some applicants being overlooked. The NRMP 2014 Program Director Survey reported that at least 80% of family medicine program directors are reviewing the following: USMLE step 1, 2, and CS scores; MSPE; family medicine letters of reference; personal statement; and the perceived commitment to our specialty. Interestingly, a Best Evidence Medical Education (BEME) systematic review found low to moderate correlation of grades, step scores, and LOR with post graduate training performance.[3]

Why is this happening? The AAMC Careers in Medicine "Apply Smart for Residency" video tells students via a looming bar graph, "Residency slots aren't growing at the same rate as graduating medical students. So, an already complex and competitive situation has become even more complex and competitive." Unfortunately, there is not huge competition for family medicine residency spots among US MD seniors and this increase in applications has not resulted in a significant increase in students choosing family medicine. From 2011 to 2015, there was an increase of just 105 US seniors matching into a family medicine residency program.[2] Additionally, the video statement made by the AAMC is not accurate according to Mullan et al. who report that the GME system is proving responsive to the increased output of US medical students and that there is *not* a shortage of GME spots.[4] The AAMC data also suggests that the unmatched rate for all US students has remained unchanged for the last 5 years, around 3%. Weissbart et al found no improvement in the match rate when students submitted an increased number of applications.[5] Despite this data, students perceive more competition and are applying to more programs and some are being counseled to use family medicine as a "backup plan."

This influx of extra applications from US students choosing family medicine, when there were more than twice as many family medicine GME positions offered last year than US MD students that were matched into family medicine, is unreasonable and unsustainable. Sifting through increased applications is not a productive use of a program director's time when there are increasing demands from ACGME around curriculum and milestone assessments. One possible solution would be to advocate for a limit on the number of applications per student. Another would be to educate students on the facts about matching into family medicine, eliminating some of the fear that is driving this change. We can promote a more holistic approach and ensure residency programs do a better job marketing what they are seeking in an ideal candidate, as well as assisting students in being more specific in identifying what type of program they are seeking. Lastly, we can advocate for social accountability and work more closely with our medical schools in encouraging more students to choose primary care as a career.

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North American Primary Care Research Group

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SUPPORTING HEALTH REFORM IN MEXICO: EXPERIENCES AND SUGGESTIONS FROM AN INTERNATIONAL PRIMARY HEALTH CARE CONFERENCE

Primary care is essential for sustainable health care.[1] Mexico is undergoing socioeconomic and health care developments, but a barrier is policy makers' poor understanding of the role and function of primary care. Consequently, the country struggles to meet the health needs of its population. The Mexican College of Family Medicine (MCFM) has the potential to lead health systems change with strong primary care, but lacks capacity. A pre-conference at the 2015 Cancun NAPCRG conference aimed to develop an action plan and build leadership capacity for MCFM (http://www.napcrg.org/Resources/CancunManifesto/SupportingHealthReforminMexico-FullPaper).

International Collaboration

There is substantial international experience in implementing primary care policy to reform health systems.[2-7] This policy implementation requires translating general principles of primary care to local circumstances and priorities; articulating primary care's contribution to population health (ie advocacy); and engaging with multiple stakeholders in a bottom-up process to address population needs.

Mexican Health (Care)

Mexico is experiencing a demographic transition, with an aging population and an increase in chronic diseases (notably diabetes mellitus).[8]

Since 1943 the Mexican Health System has covered various sectors of the population. Additional legislation was introduced in 2014[9,10] and upgraded in 2015, to ensure full health care coverage.

Despite a convergence of services,[11] each health structure that passed legislation has a vertical financing system which increases administrative expenses. In 2011 these administrative costs represented an estimated 10.8% of total expenditure on health.[9]

Coherent primary care is absent. Primary care is provided, depending on the funder, by institution-certified family physicians, general practitioners, or non-certified family physicians or social service interns.[12] Practice visits are short (12 minutes) and curative in focus, with less than 10% being preventive in nature.[13] Accordingly, family medicine accounts for only 4% of over 26,000 training positions.[14] This gives urgency to focus health reforms on primary care, including financing and training.

In summary, the most urgent issues are:

- Lack of structure and coordination between primary care and hospitals
- Insufficient coverage and access for the many poor
- Insufficient understanding of the primary care role
- Lack of teaching, training, or research of health problems in the community
- Poor socioeconomic status of family physicians

Two International Examples of Success

Ontario, Canada provides a lesson on system transformation through physician payment and interprofessional teams.[15-17] Capitation payment blended with fee-for-service and pay-for-performance incentives became the preferred reimbursement, and about one-quarter of physicians were supported with interprofessional teams.

The health transformation increased physician reimbursement and satisfaction. Students' interest in family medicine almost doubled to 40% of graduates. Important lessons learned were to adjust capitation to populations' health needs and to align primary care incentives with the needs of the rest of the health system.

The US experience, often copied in Central American countries, demonstrates that health investment does not lead to a return in health outcomes,[18] without investment in the primary care function. Additionally, markets with fee-for-service payments create mal-distribution of workforce away from areas with high health needs.

As an alternative, decentralized, local "communities of solution" are powerful in achieving more with less resources, as exemplified in the *Hombro a Hombro project* in Honduras.[19] Through an academic/community partnership, "committees" for health identified social determinants of health needing greatest attention and prioritized resources accordingly.