Increasing the Medical Professional Workforce

Nicole M. Johnson MD|

In its plan to expand insurance coverage, the ***Patient Protection and Affordable Care Act of 2010*** encouraged the use of advanced practice nurses (APRNs) as substitutes for physicians in order to reduce healthcare professional shortages the law itself helped create. In response, APRN graduation rates increased. The AANP reports on its website that the number of certificates doubled from 2016 to 2017 and grew 9% from 2017 to 2018. As of this writing, 23 US states, the District of Columbia, and the Veterans Administration now allow APRNs to care for patients independent of the supervision or collaboration agreement with a licensed physician. This expansion in practice scope has increased the numbers of these clinicians per capita but have not decreased wait times, improved affordability or care delivery. In fact, according to the Association of American Medical Colleges (AAMC) 2018 Update: The Complexities of Physician Supply and Demand: Projections from 2016 to 2030 combined with the American Medical Association's data mapping practice locations, these unsupervised APRNs are saturating health care markets already populated by physicians. A growing number of studies find that NPs order more tests and imaging than physicians and prescribe more antibiotics unnecessarily. In addition to this, demands for pay parity with physicians counter promises by the AANP that APRNs decrease the cost of care and improve care delivery models for patients.

While NPs are valuable members of the medical team and have made many notable contributions of medical care, expanding their scope of practice to unsupervised care is not

the answer to a physician shortage. The grassroots coalition Free To Care (http://free2care.org) which now represents about 2 million medical experts (including myself and the organization PHYSICIANS FOR PATIENTS®) developed a comprehensive roadmap of practical solutions that will actually improve patient access to affordable, equitable, safe, and timely physician-led care. Some of these solutions to improve the physician workforce are presented here.

1. Provide Incentives for Primary Care Physicians

Primary Care Physicians (PCPs) are in the specialty with the largest deficit per patient yet serve as the major gatekeepers of medicine providing preventive services, chronic care services, and access specialty care by referral. Because they provide the most medical care yet are reimbursed the least of all physician specialties, the incentive to become a primary care physician is low. Time-based insurance reimbursement rates, tax refunds for charitable or pro bono care, loan repayment for PCPs choosing healthcare shortage practice locations, and incentives for health systems that increase the base salary for PCPs can expand the workforce.

2. Remove Barriers for Private and Physician-Owned Practices

Many existing regulations restrict the ability of physicians to open and sustain practices yet do very little of anything to improve the quality and safety of delivered care. Evidence suggests that physician-owned and run hospitals provide lower cost and higher quality of care delivery. Because of this, the Physician Hospital Association urged Congress to the pass, the ***Patient Access to Higher Quality Health Care Act of 2017(H.R. 1156)***. Additionally, physicians not employed by large health systems are the mainstay of care for underserved populations. The number of independently practicing physicians has dramatically decreased just in the last 10-20 years. Abolishing the Stark Law in addition to 1) minimizing or removing restrictions for the Certificate of Need, 2) supporting Direct Primary Care and other direct pay models, 3) prohibiting non-compete clauses in employed physician contracts, 4) allowing tax refunds for physicians and nurses providing pro bono patient

care, and 5) removal of federal requirements such as EHR, MACRA, MIPS, and HIPAA will allow growth of smaller practices and promote simplified, cost saving options for patients to receive medical care.

3. Expand Telemedicine Licenses and Remove Barriers to Independent Telehealth Practice

Rural areas are in great need of access to medical care. Telehealth or telemedicine allows patients remote access to physicians in many specialties including but not limited to primary care, psychiatry, radiology, dermatology. Physicians who are willing and able to practice telehealth are able to offer expert medical care to patients in more than one location. In addition, these physicians have the benefit of working remotely, saving on their own childcare, travel, and other expenses. The barriers to expansion are related to restrictions on utilization. Often physicians require multi state medical licenses and these are expensive and burdensome. There should be regional or national reciprocity for state medical licensing without requirements for board certification. Other barriers include low and variable reimbursement rates, Stark Law, and issues to related to accessing broadband internet, communications equipment, training, and maintenance.

4. Expand Graduate Medical Education

According to the 2017 AAMC Physician Specialty Data Report, 47% of all graduates and 51-56% of primary care graduates remain in the state where they trained. Therefore, increased medical residents per capita improves the state's ability to grow its physician workforce especially if that number added is commensurate with population growth. Smaller states have difficulty attracting residents to small teaching facilities and need to rely on recruitment of physicians from out of state. However, larger states with growing populations can accommodate more medical residents to train. Published workforce studies such as "Measuring primary care: The standard primary care year." by Bowman, R. C. show that it takes **10 nurse practitioners to provide the care of 1 single Family Medicine resident**. Therefore, more residents trained lead to more physicians in the workforce even while they are in training and much more than increasing numbers of advanced practice nurses. In order to increase the numbers of medical residents, the US Senate introduced 3 bipartisan bills just this year to lift caps on graduate medical education

funding (GME) for these programs. Not only should we encourage passage of the ***Resident Physician Shortage Reduction Act of 2019 (S.348), Rural Physician Workforce Production Act of 2019 (S. 289), and the Training the Next Generation of Primary Care Doctors Act of 2019 (S.304)***, we should also consider private funding for training medical school graduates in order to allow innovative ways to train as well directly impact care in rural and other areas of need.

5. Adopt Graduate Assistant Physician (GAP) Licenses

GAPs are Medical Doctors (MD) and Doctors of Osteopathy (DO) who graduate from a 4-year medical school program, successfully pass all but the final step of either the United State Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX), but do not complete a residency program. These MDs and DOs are prepared to practice primary care because of the extensive education and training in medical school. They can become licensed as GAPs and work in close supervision and collaboration with fully licensed physicians. Several states have adopted licensing rules that require GAPs to be tested on clinical competency and take and pass the remaining portion of the USMLE or COMLEX in order to obtain their AP Medical License. GAPs must also complete state required continuing medical education throughout their careers. These physicians will not achieve initial specialty or subspecialty board certification unless they complete an accredited residency training program which they should be encouraged to do for safe medical practice. Adopting GAP licenses will expand the physician workforce and provide more safe, economical, and equitable medical care than non-physicians who are granted fully unsupervised practice rights. The only opposition to GAPs has been from PAs, NPs, and some medical schools who think that these doctors would compete with them for training and practicing sites. We obviously have enough patients to go around given the shortage we are facing so this opposition is unreasonable.

It is true that NPs have led to improvements in access and quality of patient care. The AANP rightly boasts years of statistical evidence supporting this. What they neglect to say is these studies do not serve as evidence that nurses can safely practice without physician supervision, but are proof that integrated physician-led teams work well. The AANP also ignores the existing shortages in the nursing workforce exacerbated by the growing supply of NPs. Therefore, nurse practitioners practicing unsupervised medicine further

complicates the medical professional workforce supply deficit instead of solving it. We should encourage nurses to advance their knowledge, skill, and leadership but doing so as a part of integrated medical teams.