

FOR THE RECORD

The Non-Physician Remedy to the Physician Shortage

In “Beyond Medical Licensure” (Spring 2015), Shirley Svorny cogently criticizes the effectiveness of state occupational licensing boards, and specifically the licensing of physicians. She further argues that medical licensure is better handled through private ordering mechanisms (including private credentialing, hospital privileging, branding, certification, and medical professional liability insurance oversight) than state medical licensing boards, which generally perform poorly in protecting patients.

While we share her concerns about unnecessary regulatory barriers “to limit the scope of practice of non-physician clinicians,” we do not go as far as Svorny in advocating for the elimination of state-level licensure of physicians. Below we offer an alternative policy recommendation.

First, we echo her concerns about the supply of health care providers. Over the last 10 years there has been increasing concern about an impending shortage of practicing primary care physicians in the United States, fueled by several factors. These include a significant percentage of American physicians reaching retirement age by 2020; an unprecedented growth in the number of Americans living beyond the age of 65 and their increasing demand on the health care system; and the influx of up to 30 million Americans entering the health care system over the next few years as a result of the passage of the Patient Protection and Affordable Care Act (ACA).

A heavily cited research study, published in 2008 by the Association of American Medical Colleges (AAMC) Center for Workforce Studies, projects a shortage of primary care physicians—internal medicine, family medicine, and pediatrics. Its estimates became even more worrisome following data projections updated in

2010 to take into account the effect of the then recently enacted ACA.

Somewhat lost in the dire warnings about a national primary care physician shortage is an equally alarming projected shortage in practicing non-primary care physicians (all specialties other than primary care specialties): 33,100 by 2015, 46,109 by 2020, and 64,600 by 2025.

There has been much discussion of the use of non-physician clinicians—including nurse practitioners (NPs) and physician assistants (PAs)—to help address the shortage in primary care physician specialties. We believe these non-physician clinicians offer considerable promise, but some policy issues must be addressed before that promise can be fully realized. Those issues are regulatory in nature, involving private ordering (in this case, professional self-regulation requirements) and the public regulation (or licensing) of both the NP and PA roles.

About NPs and PAs / According to the International Council of Nurses, an NP/advanced practice registered nurse is “a registered nurse (RN) who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of an RN, the characteristics of which should be determined by the context in which he or she is credentialed to practice.” The American Association of Nurse Practitioners (AANP) identifies educational requirements for NPs as completion of either the M.S. in Nursing (MSN) or the Doctor of Nursing Practice (DNP) degree programs, for a total of six or seven years of academic and clinical preparation.

The American Nurses Credentialing Center (ANCC) certifies NPs in their specialties, including acute care, adult, adult gerontology acute care, adult gerontology primary care, psychiatric mental health,

family, pediatric primary care, and emergency. As of 2014, there were 192,000 practicing NPs in the United States, with the AANP projecting 244,000 practicing NPs in 2025. Yet according to the AANP, as of 2013 87.2 percent of all NPs practice in specialties considered as primary care, leaving only 12.8 percent practicing in non-primary care specialties.

NP licensure is a regulatory responsibility of all 50 state governments and the District of Columbia. According to the most recent information on the state-level scope of practice environment provided by the AANP (February 2015), NPs are classified within area of specialty as either “full practice” (19 states and the District of Columbia); “reduced practice” (19 states); or “restricted practice” (12 states).

According to the American Academy of Physician Assistants (AAPA), a “physician assistant (or PA) is a nationally certified and state-licensed medical professional. The AAPA identifies educational requirements for a PA as a bachelor’s degree, with pre-professional course requirements in the basic sciences, and usually a professional master’s degree awarded, with didactic and clinical requirements of two to three years (with an average of 27 months) in program duration. The AAPA recognizes 21 areas of specialty practice for PAs, although the overwhelming majority of PAs working in their specialty were trained on the job. Graduates of accredited PA programs are eligible to take the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants (NCCPA).

The Association of Postgraduate PA Programs, however, does keep a listing of available postgraduate specialty programs for PAs. As of February 2015, there are 49 such elective certificate-granting programs, with programs available in 17 specialties. The duration of most of these certificate programs is 12 months, with the remainder ranging up to 18 months. The Agency for Healthcare Research and Quality reports that there were 70,383

PAs practicing in 2010, with 52 percent practicing in the primary care specialties. The NCCPA reports that there were 86,500 PAs practicing in mid-2012, with the U.S. Bureau of Labor Statistics projecting that the number of practicing PAs will increase to 103,900 by 2018, and 120,000 by 2022.

As with NPs, PA licensure is a state-level regulatory responsibility in all 50 states and the District of Columbia, with no statutory regulatory provision for legal recognition of specialties. PAs practice medicine under the direct supervision of a physician. Most states' PA scope-of-practice acts are written to allow the supervising physicians to evaluate the PAs' abilities and to delegate procedures and services—including PAs' prescriptive authority and limits on that authority—that are appropriate to both the PA and the nature of the health care practice.

Regulatory barriers/ Recent trends in professional regulation show promise that some of the barriers to scope-of-practice for non-physician clinicians are being addressed at the state level. In a study published in 2015 (“Trends in State Regulation of Nurse Practitioners and Physician Assistants, 2001–2010,” *Medical Care Research and Review* 72(2): 200–219), authors Emily Gadbois, Edward Miller, Denise Tyler, and Orna Intrator found that over the time period studied, most states loosened regulations for NPs and PAs with respect to authorizing prescriptive authority and physician involvement in treatment and diagnosis. But the states also increased barriers to entry by requiring higher levels of education before the clinicians can enter practice.

NPs are overwhelmingly focused on providing primary care service in the U.S. health care system, and this trend is not likely to change in the near future. However, in the area of non-primary care physician specialty shortages, one area in particular stands out: there is a chronic shortage of psychiatrists in the United States. The use of non-physician clinicians is one way to help meet the psy-

chiatric mental health needs of patients now facing long waits for appointments with psychiatrists. Yet, according to the AANP, as of 2013, only 3.2 percent of all NPs are certified as psychiatric mental health NPs. An expansion in the number

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of psychiatric mental health MSN/DNP programs nationwide, along with other educational financial incentives, could generate interest in students considering this specialty.

State regulations and improved educational standards need to work in harmony to better meet common goals in addressing medical shortages. For example, 31 states have yet to legislatively authorize “full [scope of] practice” status for NPs. Moreover, incentives for PAs for expanded study and specialized training in psychiatric mental health are also needed. In the competition for NP talent, the 19 states and the District of Columbia that are “full practice” states have a major advantage in utilizing (and attracting) NP talent in a non-primary care specialty such as psychiatric mental health or in other non-primary care specialties. The use of “telepsychiatry,” or providing mental health care via video technology, is another method of making psychiatric mental health services from psychiatrists and psychiatric mental health NPs available to patients, especially in rural or other underserved areas. In states with regulatory barriers to offering such service, reconsideration of removing barriers is of paramount importance.

PAs, unlike NPs, are confronted by a lack of harmonization in educational requirement standards. We recommend standardizing the basic PA curriculum to two years (post undergraduate), followed

by one year for post-graduate didactic and clinical training in a certificate-awarded specialty. Certification examination and maintenance in each specialty can be governed by the NCCPA, as further specialty licensure is unnecessary because health

care employers would require evidence of specialty certification upon hire and further maintenance of certification while employed (following the model now in effect for physicians). As PAs are more likely to enter non-

primary care specialties than their NP counterparts, this recommended private standardization approach will ultimately improve the quality in each specialty and reduce the time period to thoroughly educate PAs in primary care and non-primary care specialties.

Through a combination of professional self-regulation and public regulatory reform measures, we believe that the shortage in non-primary care physicians can be partially alleviated through increased scope of practice authority for NPs, and improvements in the quality of specialty education and training for PAs. These recommended regulatory policy improvements are not intended to replace non-primary care physicians; they are, however, intended to fully utilize clinicians' distinct health care skill sets, with a common understanding of the complementary roles of physician and non-physician clinicians in the delivery of health care services. Proper utilization of inter-professional teams and technology in the delivery of health care offers promise for the future of health care services.

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