



Insight

Affordable Care Act and Doctor Shortages: A Bad Situation Worsens

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With the implementation of the 2,800 page Patient Protection and Affordable Care Act (“Affordable Care Act”), the projected access of 34 million additional Americans to health insurance, along with the growth in both the general and aging population, is placing greater emphasis on the need for an increase in the number of primary care physicians (“PCPs”). In a recent study (“Projecting US Primary Care Physician Workforce Needs: 2010-2025”) published in the *Annals of Family Medicine*, this increase in demand for PCPs, the health care “gatekeepers” under the Affordable Care Act, is projected to require nearly 52,000 additional PCPs by 2025. Patient office visits are forecasted to increase from 462 million annual visits in 2008 to 565 million in 2025, a 22.3 percent increase.

According to the above study's results, population growth will be the largest driver of this demand for service (33,000 additional PCPs), and an aging population a secondary contributor (10,000 additional PCPs). In short, the ACA is responsible for 8,000, or 15.4 percent, of the anticipated national demand for additional PCPs.

While the ACA has financial provisions to incentivize medical students to become PCPs, these provisions are only expected to encourage 500 additional PCPs per year. Moreover, a study (“Income Disparities Shape Medical Student Specialty Choices”) published in the *American Family Physician* found that there was an income gap of \$135,000 in the median annual subspecialist income from that of PCPs, yielding a \$3.5 million difference (“financial loss”) in expected income for PCPs. Furthermore, the Center for Workforce Studies, American Association of Medical Colleges' study also forecasts nearly one-third of all physicians will retire by 2020; many of them undoubtedly encouraged by the ACA's restrictions on personal autonomy, bureaucratic regulation, and diminished job satisfaction. There are presently 48 million American senior citizens on Medicare, the overwhelming majority of them receiving healthcare services from PCPs. With Medicare “savings” over the next decade being used to finance the ACA, Medicare reimbursement rates are being significantly reduced to where operational costs are not remotely covered, causing many PCPs to not accept new Medicare patients.

How will the U.S. healthcare system compensate for this shortfall in PCPs? According to the 2012 Great American Physician Survey, 44.9 percent of physicians surveyed reported that PCPs will be replaced by cost-efficient, non-physician primary care providers in the next five years. By “non-physician primary care providers” these respondents mean nurse practitioners and physician assistants who, studies show, can attend to 80 to 85 percent of primary care patient needs. While physician assistants are legally required to practice under the supervision of a doctor, individual state law determines whether nurse practitioners can work independently of a physician. As of February 2013, 16 states and the District of Columbia allowed nurse practitioners to diagnose and treat patients and prescribe medications without a doctor's involvement, while 32 states required physician involvement to diagnose and treat or prescribe medication, or both. According to the results of a national survey undertaken by the American Academy of Physician Assistants in 2009, nurse practitioners accounted for 27 percent of primary care providers and physician assistants 15 percent.

Productivity figures based on 2008 physician compensation and productivity data, and published in the May 2012 edition of *Virtual Mentor* (“Physician Assistants and Their Role in Primary Care”), suggest that a physician assistant working in a large practice could be the equivalent, on average, of being 0.74 to 0.96 of a full-time equivalent (FTE) family practice physician. Similarly, a nurse practitioner offsets the work of 70 to 90 percent, on average, of a FTE primary care physician. There is also a substantial body of research examining the quality of primary care provided by nurse practitioners and physician assistants. These study results show that they perform as well as physicians on such important clinical outcome measures as mortality, improvement in pathological condition, reduction of symptoms, health status, functional status, and that patients are generally more satisfied with primary care provided by nurse practitioners.

This PCP shortage will encourage the implementation of new health care management practices, some beneficial to the American health care consumer, others less so. Recently published research (“Primary Care Physician Shortages Could be Eliminated Through Use of Teams, Nonphysicians, and Electronic Communications”) in *Health Affairs* recommends that by directing some patients to nurse practitioners and physician assistants, the doctor-to-patient ratio (presently 1:2,500) can be stretched to compensate for most (if not all) of the nation's anticipated increase in patient visits and shortage of PCPs. Another method of stretching the doctor-to-patient ratio, say these health care scholars, is the “pooling” of two or three physicians utilizing a practice-wide electronic health record system in conjunction with a nurse practitioner or physician assistant. Also, these health care researchers foresee PCPs reducing the need for in-person visits by employing electronic communication technologies with some patients.

But Atul Grover, chief public policy officer for the Association of American Medical Colleges, cautions for restraint in accepting these solutions: “Our position is that you do have to have that stuff (i.e., physician pooling strategies, enhanced use of nurse practitioners and physician assistants, and electronic communications with patients), but you also have to train a couple thousand doctors a year – it's not an either or proposition.” Moreover, this “pooling” strategy could hinder continuity of care and adversely impact patients' freedom to choose their own individual provider of primary health care services. With fewer PCPs, and greater demand for their time, the availability of a specific physician that a patient has developed a trusting relationship with will become increasingly difficult to maintain, thus further restricting freedom of patient choice (although the belief that a majority of patients are still being treated by a single PCP is no longer the case).

Public policy that actively encourages an expansion in the supply of nurse practitioner and physician assistant primary care service providers is certainly warranted. Resistance to expanding scope-of-practice laws for nurse practitioners by physician groups, alleging that such laws will place patient health at risk (although repeated studies show this to be false), is a regulatory barrier to addressing growing nationwide primary health care needs. The credentialing and payment policies of managed health care plans are linked to state practice laws, thus often constraining the role of nurse practitioners in delivering primary care. However, exacerbated by the

implementation of the Affordable Health Care Act, political resistance to expanding the scope-of-practice of nurse practitioners will likely dissipate over the next few years when local legislators are confronted with the reality of primary care demands in their home states.