



Expanding the Primary Care Workforce

An Essential Element of Health Care Reform

By Ellen-Marie Whelan November 2009

Congress is in the throes of developing legislation to provide quality affordable health for all Americans. Discussion throughout the debate has questioned whether there are sufficient primary care professionals to provide services for the newly insured individuals, since the nation's primary care health workforce is already stretched.¹ This is a concern, but targeted policy changes can begin to strengthen and expand this sector, which is the backbone of the health care system.²

The American Recovery and Reinvestment Act and the president's budget proposal for fiscal year 2010 included provisions to address this ongoing shortage. Any new health care reform legislation will need to include strong measures to make sure we can continue and build on this investment. Solutions include providing more scholarships and loan repayment plans for clinicians who agree to work in primary care specialties and underserved areas, making more and better use of primary care physicians, nurse practitioners, and physician assistants, and improving the environment for delivering primary care, including increased reimbursement rates and more flexibility in providing services.

The shortage

There are not enough primary care providers to meet current needs. We will need targeted policy changes to ensure that we are well-positioned to provide services to the additional millions of Americans who will have health insurance under health care reform.^{3, 4} Massachusetts provides a case in point; the state passed universal coverage in 2008, and there is now concern that there are not enough basic health services providers to accommodate the newly insured.^{5, 6}

The main reason for this shortage is that medical students do not generally choose to work in primary care. This has been a longstanding and worsening issue; the number of medical school graduates entering family medicine residencies dropped by 50 percent between 1997 and 2005.⁷ Primary care training programs are closing nationwide—despite the over-

whelming need. About 40 primary care residency programs closed between 1995 and 2006 because they weren't being filled.⁸ We are increasingly seeing primary care physicians who received their basic medical training internationally. Medical students trained outside the United States filled about 58 percent of the 2,603 family practice residencies slots in 2007.⁹

The American Academy of Family Physicians predicts that, if current trends continue, the shortage of family doctors will reach 40,000 in slightly more than 10 years, as medical schools send about half the needed number of graduates into primary medicine.¹⁰ A significant concern is the time it will take to change the current trends. Experts worry that we need to dramatically change the way we train physicians in order to entice the critical mass of medical students to choose to be generalists.¹¹ This is quite an undertaking, and since it takes at least 12 years to train new primary care physicians, this must be a longer-term solution.¹²

One reason medical students do not choose to enter a primary care specialty is economic. Medical school is expensive. The cost of a public school medical education has doubled over the past 15 years, and private school tuition has increased by 133 percent.¹³ The average medical student has \$155,000 of debt upon graduation. And primary care clinicians earn far less than specialists. The average annual income for family physicians is \$173,000, while oncologists earn \$335,000, radiologists \$391,000 and cardiologists \$419,000.¹⁴ Study after study has demonstrated a strong correlation between U.S. medical students' specialty choice and the overall mean salaries of those specialties.¹⁵

Where to start?

Expand the National Health Service Corps

The most immediate solution to begin to address the primary care workforce shortage is to expand the National Health Service Corps. The NHSC is a scholarship and loan repayment program that was designed in 1972 to address the workforce shortage by attracting and placing primary care, dental, and mental health providers into areas of the country facing the largest shortages. More than 30,000 clinicians have served in the corps since its inception, expanding access to health services and improving the health of people who live in urban and rural areas where health care is scarce. Loans and scholarships are available to dentists, physicians, nurse practitioners, physician assistants, and certified nurse midwives. These funds will help alleviate the economic pressures that may cause medical and other primary care students not to pursue a primary care specialty.

About half of all NHSC clinicians work in Community Health Centers, which deliver preventive and primary care services to patients regardless of their ability to pay. Not only are there more primary care providers deployed to underserved areas; these providers are also better serving Americans without health insurance since about 40 percent of the patients seen at Community Health Centers are uninsured.

Despite its success, funding for the NHSC dropped dramatically under the Bush administration. There were only enough funds in 2008 for 76 new scholarship awards and 867 new loan-repayment awards. Increasing funding for this program will immediately bring generalist providers to areas with the greatest primary care shortages. And those who receive a loan or scholarship are more likely to ultimately choose a career in primary care and continue working in that area.¹⁶

Congress and the White House boosted funding for the NHSC earlier this year in the American Recovery and Reinvestment Act.¹⁷ A provision in ARRA more than doubled funding for this program by adding \$300 million to the \$135 million appropriation for FY 2009.¹⁸ The program is expected to serve an additional 8,108 clinicians serving almost 9 million people by the end of the year as a result of the additional ARRA funding.¹⁹ Congress has also identified the importance of this program and included provisions to strengthen it in the health reform legislation currently being developed and debated on Capitol Hill.

Pay primary care clinicians more fairly

Another important step to not only reward those currently delivering primary care but also help make the field of primary care more attractive, is to pay providers more for the delivery of primary care services. There is near universal agreement on Capitol Hill that we must increase reimbursement rates for services provided by primary care specialties. Proposals from the Medicare Payment Advisory Commission and provisions included in reform legislation being developed in both the House and the Senate would increase the reimbursement rate for many primary care services, including office visits, by 5-10 percent.^{20, 21, 22}

Other proposals include more innovative ways to pay primary care clinicians better that would simultaneously change the way care is delivered and improve patient outcomes. Primary care clinicians are often frustrated with the current fee-for-service reimbursement method that pays for each individual service or procedure, and usually reimburses more technical elements at high levels while giving short shrift to primary care services. This ends up rewarding activity rather than outcomes. New models of payment—such as the medical home incentive—would pay providers an additional bonus payment for assuming responsibility for and providing a full range of primary care services. This would increase primary care providers' overall income, give them more control over the type of health care they deliver, and provide incentives to improve quality and outcomes. As an added benefit, if general practitioners do a better job in the primary care settings, they may prevent some more acute treatments and excess patient visits to high-paid specialists.

Paying primary care providers for improved patient outcomes rather than just fee-for-service also encourages a more collaborative approach to care delivery. Instead of having to monitor every individual service provided, primary care clinicians could function more as “team leaders” providing oversight in the overall goal to make patients healthier.

This would then free some of their time and allow them to provide broader care to more patients. It would also maximize the role of many different members of the health care delivery team, including nurses, care coordinators, medical assistants, and even lay home workers; ultimately extending the reach of those primary care providers. Both the House and the Senate health reform proposals include these and additional new models to pay for health care delivery.²³

Maximize the current primary care workforce

One solution gaining more attention to help address the growing demand for more primary care providers is better use of nurse practitioners and physician assistants.^{24, 25, 26} Expanding the role of NPs and PAs in primary care is a cost-effective solution to the looming primary care shortage. In fact, both were created nearly a half century ago to address this very problem. There are currently 125,000 practicing NPs and nearly 74,000 practicing PAs in the United States.^{27, 28} The quality and cost-effectiveness of both NPs and PAs is well-documented.^{29, 30}

NPs and PAs have been providing quality, cost-effective health care since the 1960s. We can rapidly expand our primary care workforce effectively and efficiently by training more of these clinicians.^{31, 32} The timeline for training NPs and PAs is half that of a primary care physician—only six years rather than 12 years post high school. Six years is also the amount of training for European primary care physicians, who begin medical training immediately after secondary school. The majority of the educational expense accrues in medical school and residency training, and it is estimated that training nurse practitioners and physician assistants is 20 to 25 percent of the cost of training a physician. Salaries for NPs and PAs are also less than half the average salary of a primary care physician—the base salary of a NP or PA is just over \$82,000.³³

Economic and lifestyle reasons may prevent medical students from choosing to become primary care providers, but this is not so for NPs and PAs. The Government Accountability Office has found that the number of NPs and PAs continues to grow much faster than the number of primary care physicians.³⁴ Last year the number of primary care NPs rose by over 9 percent and PAs by nearly 4 percent, while the number of primary care physicians increased only about 1 percent. About 6,000 new NPs and 4,600 PAs are educated each year in the United States.

NPs and PAs are already included as eligible providers in the National Health Service Corps, and more funding for this program will enable the nation to provide assistance to even more of these primary care clinicians who agree to serve in underserved areas.

An immediate solution to the primary care shortage is to encourage greater use of already trained NPs and PAs. Some insurance plans only reimburse care delivered by physicians even though other providers can adequately deliver the same services. Any primary care

Nurse practitioners, or NPs, are registered nurses who are prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services.

Physician assistants, or PAs, are also generally trained at the master's degree level and licensed to practice medicine under the supervision of a licensed physician and perform duties generally performed by a physician.

bonus payment—an additional payment paid to clinicians who provide primary care—should also be made available to all primary care providers. Health reform bills moving through Congress include nurse practitioners, physician assistants and other advanced practice nurses in most proposals. Yet this will likely only affect government-sponsored health plans. It will also be important for private plans to adopt similar policies to fully engage all eligible providers.

The primary care shortage requires us to maximize the use of every health care professional to the full extent of their training and competency. As health economist Mark Pauly, professor of health-care management at the Wharton School of Business argues, “making greater use of advanced practice nurses is one way to trim costs and maintain high quality.” But he suspects there are few instances of such “low-hanging fruit.”³⁵

Should we train more doctors?

There is currently some debate about whether or not we have an overall shortage of doctors. Some researchers speculate that the shortage is pervasive among all physician specialties,^{36, 37} but others are convinced that there are enough health professionals in the country to meet the demand—we just need to better utilize them.^{38, 39} The concern is that by simply increasing the overall number of physicians without targeting areas of need, we will likely just perpetuate the oversupply of specialists. The American Association of Medical Colleges, the lead organization representing teaching hospitals, advocates a 30 percent increase in medical school enrollment to produce 5,000 more doctors each year. But if we merely increase the overall number of doctors, this will likely produce more specialists—as is presently the case—and intensify the imbalance between specialists and generalists.

It is therefore more efficient and cost-effective to promote policies that specifically target the preparation of more primary care physicians. Assistance with student loans and scholarship programs—such as the National Health Service Corps—is one way to encourage medical students to choose primary care and go a long way to help with medical school costs. And it has the secondary bonus of getting more providers into the areas of greatest need.

States are currently adopting this type of policy. Legislative leaders in Massachusetts, for example, have proposed bills to forgive medical school debt for those willing to practice primary care in underserved areas, and New York passed a similar law earlier this year.⁴⁰ Scholarships will take longer than loan repayment programs to get qualified physicians into high-need areas, but these policies demonstrate a commitment to getting the right providers to the right places.

Another way to produce more primary care physicians is to target residency programs that successfully train generalists. A number of residency slots in some teaching hospitals remain unfilled every year, and current law restricts the number of new slots that hospi-

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tals can create. The federal government could allow redistribution of unused residency positions to other teaching hospitals that agree to expand their primary care and general surgery residency positions. Residency training rules also make it difficult for residents to train outside the hospital in community-based sites. A related proposal would reverse burdensome Medicare regulations that make it difficult for teaching hospitals to train residents in non-hospital settings and allow them to expand to community primary care sites. Both the House and the Senate health reform legislation contain similar proposals.

Conclusion

Solutions are already underway to fill the shortage of primary care providers in preparation for health care reform. The Obama administration has already acted to expand programs to increase the number and utilization of primary care providers. And as health care reform legislation develops on Capitol Hill, legislators are including important provisions to continue this commitment. Policies should target new graduates with assistance to pay for their training, make the field of primary care more attractive to incoming students, and reward and expand those who already provide these services. Better use of the entire health care workforce will go a long way to maximize primary care and ultimately and efficiently improve health outcomes.

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