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Team offers solutions to looming health-care provider shortage

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Thanks to a wave of aging baby boomers, epidemics of diabetes and obesity, and the Affordable Care Act, which aims to bring health care coverage to millions more Americans, the United States faces a severe shortage of primary health care providers.

In a series of papers published in the November 2013 issue of *Health Affairs*, researchers at UC San Francisco advocated a number of potential solutions to the problem.

In an analysis and commentary, Thomas S. Bodenheimer, MD, MPH, a UCSF professor of family and community medicine, and Mark D. Smith, MD, MBA, president and CEO of the California HealthCare Foundation, cited estimates that the U.S. will have a shortage of 52,000 primary care physicians by 2025. To meet the shortage, they suggested the creation of physician-led patient care teams of licensed and unlicensed health care personnel who have been empowered to provide an expanded scope of care. They also advocated increased participation by patients in providing more of their own care.

"The traditional solution to a shortage of physicians has been to mint more," said Smith. "But that won't close the gap, because demand is too strong and too few medical students are choosing primary care."

Instead, said Bodenheimer, "The gap can only be narrowed by empowering all team members to care for a large number of patients based on the team members' training and abilities."

The authors' recommendations include:

- Empower registered nurses, pharmacists and physical therapists to provide care for "uncomplicated" medical problems such as respiratory and urinary tract infections, low back pain, diabetes and high blood pressure.
- Let unlicensed medical assistants assume responsibility for preventive care needs and patient coaching for chronic conditions such as diabetes, high cholesterol, and high blood pressure.
- Use new diagnostic technologies to permit patients to perform self-diagnosis and administer their own medications for chronic conditions such as diabetes, high blood pressure and cardiovascular diseases requiring anticoagulation agents, while encouraging patients to serve as peer coaches for other patients with the same conditions.

"These recommendations are all evidence-based," said Bodenheimer. "Research indicates that these approaches not only work, but actually tend to increase patient satisfaction compared with care by physicians."

In another analysis and commentary, a group of authors led by Catherine Dower, JD, Health Policy and Law Director of the UCSF Center for the Health Professions, reinforced the conclusions of Bodenheimer and Smith from a legal perspective.

Dower and her team analyzed current laws governing scope of practice, which they defined as "what services may be provided by which health professions under what conditions." They concluded that existing laws and regulations, which are determined on a state-by-state basis, prevent most health professionals from providing the full scope of health care services that they have been trained and are qualified to provide. This mismatch between professional competence and scope of practice, said

the authors, results in higher health care costs and needless inefficiencies.

"Our licensing laws have not kept pace with increasingly higher levels of education and better technology," said Dower. "For example, many state laws don't allow nurse practitioners [NPs] to see patients without physician supervision, even though NPs are educated, trained and tested to do so."

Furthermore, she said, the existing "patchwork approach" to the regulation of health professions, with each state passing its own set of laws, is a disservice to patients, professionals and health care employers alike.

"The health professions regulatory system in the U.S. includes outdated laws and regulations, is not standard across states and is too often guided by politics rather than evidence," Dower said.

The authors recommended a number of legal and regulatory reforms, including:

- Align scopes of practice with professional competence.
- Make regulations easier to update, to better reflect professional advancement.
- Recognize and accommodate overlapping scopes of practice between different health professions.
- Mandate public participation in regulatory bodies that determine scope of practice, thus ensuring a voice for consumers and patients.
- Use best available evidence in setting regulatory policies.
- Create a national clearinghouse that provides up-to-date information and research about emerging health professions and scope-of-practice expansions for use by states in creating policy.

"Old ways of regulating health care professionals result in unnecessary restrictions, limited choices and higher costs," concluded Dower. "We are restricting the full use of a workforce whose education and training is subsidized by public dollars."

Co-authors are Jean Moore, BSN, MSN, and Margaret Langelier, MS, of the State University of New York Albany.

A research team led by Joanne Spetz, PhD, professor of economics at the UCSF Philip R. Lee Institute for Health Policy Studies and associate director of research strategy at the UCSF Center for the Health Professions and Stephen T. Parente, PhD, MPH, MS, of the University of Minnesota presented evidence that liberalization of scope-of-practice laws for nurse practitioners could potentially achieve significant savings in the cost of visits to retail clinics.

According to the authors, NPs are the primary health care providers in such clinics, which offer diagnosis and treatment for common, non-life-threatening health conditions. They are located in settings such as pharmacies, grocery stores and big-box retailers.

The team compared the two-week cost associated with a clinic visit for 9,503 patients in 27 states who visited retail and non-retail clinics at some point between 2004 to 2007. In 13 of the states, NPs were allowed to practice independently, without the supervision of a physician; in six of the 13, they were also permitted to prescribe independently. The remaining 14 states required NPs to be supervised by or collaborate with a physician.

Adjusted to 2013 dollars, the average two-week cost for a non-retail clinic visit was $704. In states where NPs required physician supervision or collaboration, the cost was $543. In states where NPs were allowed the practice independently, the cost was $484; it was $509 in states

where they both practiced and prescribed independently.

Based on a projection that retail clinic visits will account for about 10 percent of all outpatient primary care visits by 2015, the authors estimate that the national cost savings from such a level of use will be $2.2 billion. They estimate that if NPs were allowed to practice independently all 50 states, the savings would increase by $810 million; if they were allowed to prescribe independently as well, the savings would increase by $472 million.

"Our findings underscore earlier research indicating that when NPs practice to the full extent of their training, they can deliver highly efficient high-quality primary care," said Spetz. "We believe that primary care practices should leverage NPs' knowledge and skills and the increased availability of convenient care delivery settings to expand access to health care."

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