Who's On First: A Look at Workforce Projections

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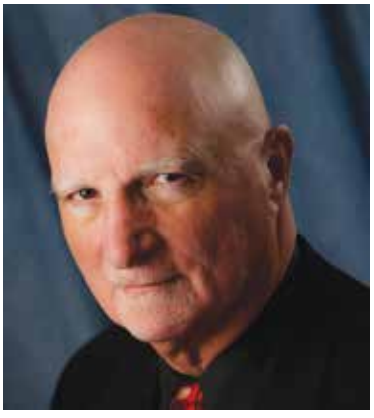

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Predicting the future, particularly in the ever-changing realm of health care, is always a gamble. The variables with the potential to impact health care—among them, unpredictable political agendas, unforeseen economic upheaval, and technological issues—make it difficult to identify one "expected" outcome. However, one forecasted trend will certainly make a difference: the quantity of well-educated health care practitioners.

This factor will be one of the most important determinants of our ability to deliver quality, accessible health care in a diverse society with increasingly complex medical needs. Some may say that this is an irrational fear—the US health care system is remarkably adaptable, and as far as we can tell, no serious problems have arisen due to a shortage of providers. So are we overreacting, or is there a viable reason for concern?

While more and more Americans are covered by health insurance thanks to the Affordable Care Act, fewer physicians are entering primary care. The Association of American Medical Colleges (AAMC) has projected a shortage of between 46,000 and 90,000 physicians by 2025. AAMC forecasts a shortage of 12,500 to 31,100 primary care physicians and 21,200 to 63,700 non–primary care physicians; much of the latter deficit will be in the surgical specialties.[1] The report emphasizes the need for immediate action because it takes almost a decade to educate a physician for entry into the workforce.

On the surface, these numbers are quite staggering. They may even elicit a sense of doom about access to quality (or even simply adequate) health care in the next decade. To put these projections in context, here are some key statistics

- About 915,000 physicians actively practice in the US.[2]
- Each year, about 20,000 medical school students graduate and enter postgraduate education.[3]
- Thirty percent of physicians are older than 60.[2]
- In 2015, there were 100,000 practicing PAs, with an average age of 38.[4]
- As of 2016, there are 222,000 practicing NPs, with an average age of 49.[5]

The US population is projected to increase from 310 million in 2015 to 335 million in 2025.[6] There are approximately 45 million Americans older than 65, a number that is projected to increase to almost 70 million by 2025.[7,8]

This inverse relationship—more potential patients and fewer people to care for them—suggests perilous changes for our health care system. Some anticipated changes—longer wait times for care, increased costs, and more opportunities for error—are real and have already been quantified in reports.[9] But with the year 2025 less than a decade away, where is our sense of urgency? Even if we implement changes immediately,

they are unlikely to offset the consequences of the workforce shortage. Yet to do nothing will lead to a rapid decline in quality of life for many Americans.

In theory, there are two ways to address this pending "crisis." We can decrease demand and/or increase supply. In the next few decades, achieving the former will be difficult, because of the unavoidable toll of an aging population. Public health and preventive services may have some impact and deserve increased attention. New and improved modes of treatment offer the potential to ameliorate the impact of chronic diseases such as diabetes and cardiovascular disease. This method, while a noble goal, is also less predictable and harder to "plan" for.

The most direct approach (but certainly not the only one) is to increase the supply of health care providers—specifically, NPs and PAs—in order to meet the rising demand. The professions have long been touted as a solution to problems of access to care in both rural and urban areas. About 83% of NPs are certified in primary care; we cannot ignore the fact that only 24% of PAs practice in primary care while the rest have chosen specialties. But (another plus) patients tend to be as satisfied with care provided by NPs and PAs as by physicians.[10,11]

Increasing the supply of NPs and PAs requires educating more individuals to enter the professions. Education programs need to do a critical analysis of their curricula to ensure that what happens in the classroom matches real-world needs. If graduates enter the workforce unprepared for the demands of the job, no progress will be made. (For a vigorous discussion on the current state of professional education, please visit www.mdedge.com/clinicianreviews/commentary).

One significant limitation to the growth of the PA supply is the accreditation process, which now takes almost three years from the start of the process until the initial approval of a class (and five years until the first class graduates). This process adds time and expense to the creation of new education programs, many of which await approval and lack the resources to bring the program to maturity. While no one would argue the value of the ARC-PA accreditation, the process should be critically examined to identify any areas that can be streamlined without decreasing the quality of the product.

Which brings us to perhaps the most important aspect of this discussion: What actions need to be taken to mitigate the possible damage of a physician shortage? Here are some recommendations for a variety of stakeholders:

Educators should enhance their competency-based curriculum to enable NPs and PAs to move through their programs at a faster stride (again, without sacrificing valuable learning time) and get into practice sooner.

Accreditors should review current standards and remove barriers to allow education programs to create innovative curricula that help NPs and PAs gain the knowledge (and experience) they need to move into practice.

Regulators should ensure that NPs and PAs are able to practice to the fullest extent of their license and scope of practice (ie, full practice authority, scope of practice determined at the practice level). Barriers should be removed to allow these clinicians to function in rural and underserved regions of the country (eg, adaptable collaboration requirements).[10] (For a different perspective on PA autonomy, see page 12.)

Policymakers should rally around the removal of barriers to postgraduate residencies, which would sustain and possibly increase the physician supply. Reimbursement, particularly in Medicare, should be re-evaluated to assure that *all* providers are reimbursed for same services. Lack of parity in reimbursement infers a difference in quality that is just not the case.

Practicing NPs and PAs should step up to the plate and volunteer as preceptors to give NP and PA students the opportunity to learn from the best and most experienced.

Physicians should seek out alternatives to retirement from medicine (ie working part-time, becoming an educator). Expanding the period of clinical practice may forestall, or even prevent, some of the shortage—at least, in the short-term.

There are those who say that a provider shortage does not exist and that those crying out about it have a vested interest in expanding medical school output. Others acknowledge the shortage but worry that increasing the supply of NPs and PAs will ultimately "devalue" individual providers (ie, drive down salaries). One thing, however, is certain: As Danish physicist Niels Bohr said, "Prediction is very difficult, especially if it's about the future."

What are your thoughts and ideas about the health care workforce and the increasing demand for care? Please share them with us by writing to PAEditor@frontlinemedcom.com. **CR**

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