Backgrounder

Published by The Heritage Foundation

No. 2493
November 29, 2010

Not Enough Doctors? Too Many? Why States, Not Washington, Must Solve the Problem

Roger E. Meyer, M.D.

Abstract: *The states are far better equipped than the federal government to address increasingly complex and serious health care workforce issues. But by enacting the Patient Protection and Affordable Care Act of 2010, Congress swells the costs and role of the federal government, while ignoring the critical role that states can—and should—play as a consequence of their existing oversight of key workforce areas. Worse, the new health care law largely repeats the mistakes of the past: pursuing failed policies, while adding needlessly to federal spending, potentially deepening the budget deficit. Congress is, once again, committing the states to unfunded and underfunded federal mandates.*

Workforce projections for physicians in the United States have a long history dating back to the Flexner Report in 1910.[1] Since 1981, however, the history of these efforts has been marked by erroneous (and, at times, contradictory) judgments offered by panels of wise persons, and by counterarguments from forceful dissidents brave enough to challenge the "consensus."[2] Government officials at the federal level have repeatedly attempted to solve the *perceived* physician workforce problems (oversupply, undersupply, and the real maldistribution of physicians by geography and specialty) through the creation of bureaucratic structures and federal grant programs designed[3] to modify or reverse long-term trends. These efforts have had a less than stellar record; and yet, with the passage and signing of the Patient Protection and Affordable

Talking Points

- Since 1981, projections of the health care workforce have been unreliable. The federal government has attempted to solve physician problems (oversupply, undersupply, and maldistribution of physicians by geography and specialty) through bureaucracy and changes in funding.
- Despite consistent failures of the government's top-down approach, President Obama and Congress have pursued the same general policies through the Patient Protection and Affordable Care Act of 2010.
- The White House and Congress have doubled down on the usual and customary federal solutions to perceived workforce problems.
- Instead of repeating past failures, Congress should convert HRSA workforce-related programs and consider Medicare support for graduate medical education into block grants to the states.
- The states should determine the size and makeup of the health care workforce within their borders. They are much better suited to address these issues than an expanded federal bureaucracy.

This paper, in its entirety, can be found at:
http://report.heritage.org/bg2493

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

Care Act (PPACA), the usual and customary federal solutions to perceived workforce problems have been "put on steroids." For example, in addition to the existing entity at the federal level that has produced *periodic* reports on the projected physician workforce, the Council of Graduate Medical Education (COGME), Congress created a new entity to provide federal officials with "objective" advice on workforce projections across the health care professions on an *annual* basis.

In part to address the expected shortage of primary care physicians, Congress authorized new individual, time-limited grants to expand community health centers and other entities at the local level. Past efforts to use these community centers as training sites has not reversed the declining interest in primary care among graduating medical students. The most straightforward step that Congress could have taken to address the projected physician workforce shortage would have been to increase the number of residency training positions for graduates of U.S. allopathic and osteopathic medical schools—especially directing a portion of the increase to primary care slots. Instead, the new law expands staff and programs at the Health Resources and Services Administration (HRSA) that have had only a marginal effect on the composition of the health care workforce.[4]

Finally, the PPACA imposes new unfunded mandates on the states, while ignoring their centrality to workforce issues. While the accreditation of undergraduate and graduate medical education, as well as the education of nursing and other health care professionals, rests with the separate health professions, the individual states have an optimal toolkit to monitor and address workforce shortages and maldistribution. States license institutions of higher learning within their borders. They oversee licensing of health care professionals and health care facilities. They determine the scope of practice across health care disciplines. They regulate the sale of health insurance, apart from the Employee Retirement Income Security Act (ERISA) exemption. States are in the best position to identify physician shortages across specialties within their borders, as well as the most cost-effective solutions. States are in the best position to determine when, and under what conditions, the scope of practice and insurance reimbursement for non-physicians would be an acceptable alternative model of health care.

As some states have faced a shortage of obstetricians due to confiscatory malpractice insurance rates for this essential medical specialty, some legislatures have been able to pass model reform statutes. As tort reform proceeds across states, it should be possible to examine the effect on the distribution of shortage specialties—as well as the impact of tort reform on the costs of health care. The good news and the bad news is that states have to balance their budgets each year: good, because they are forced to deal with competing priorities; bad, because unfunded federal mandates, like those in the PPACA, oblige states to cut other core programs.

1. Abraham Flexner, "Medical Education in the United States and Canada," The Carnegie Foundation for the Advancement of Teaching, Bulletin No. 4, 1910, at *http://www.carnegiefoundation.org/sites/default/files/elibrary/Carnegie_Flexner_Report.pdf* (October 27, 2010).
2. Graduate Medical Education National Advisory Committee, Summary report of the GMENAC to the Secretary of Health and Human Services, Vol. 1, Government Printing Office, April 1981 (DHHS publication No. (HRA) 81-651); Council of Graduate Medical Education, Summary of third report, "Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century," Health Resources and Services Administration, 1992; Council of Graduate Medical Education, "Physician Workforce Guidelines for the United States, 2000–2020," 16th Report, Health Resources and Services Administration, January 2005; and Richard A. Cooper, "Perspectives on the Physician Workforce to the Year 2020," *Journal of the American Medical Association*, Vol. 274, No. 19 (November 15, 1995); pp. 1534–1543, at *http://jama.ama-assn.org/cgi/content/abstract/274/19/1534* (October 27, 2010).
3. David Blumenthal, "New Steam from an Old Cauldron—The Physician-Supply Debate," *The New England Journal of Medicine*, Vol. 350 (April 22, 2004), pp. 1780–1787, at *http://www.nejm.org/doi/full/10.1056/NEJMhpr033066* (October 27, 2010).
4. Daniel J. Derksen and Ellen-Marie Whelan, "Closing the Health Care Workforce Gap: Reforming Federal Health Care Workforce Policies to Meet the Needs of the 21st Century," Center for American Progress, December 2009.

A Better Policy. There is a better way. Rather than expand the funding for HRSA, Congress should convert the various training-related (and perhaps other) programs funded by this agency into block grants to the states. This would enable states to build upon their critical roles in the oversight of the health care workforce and encourage them to craft solutions relevant to their unique requirements. When the Reagan Administration collapsed the separate mental health service programs supported by the Alcohol, Drug Abuse and Mental Health Administration into block grants to the states, the clinical care system that emerged was able to "bend" the cost curve while offering more choice to patients and families through a more diverse workforce and other innovative strategies.[5] By virtue of the breadth of their oversight, states are in the best position to define the needs and develop the models for the future workforce across the health professions.

A History of Federal Failures

In the context of expanded health care coverage for the elderly (Medicare) and the poor (Medicaid) in the mid-1960s, and the publication of a prior report by the Surgeon General's Consultant Group on Medical Education[6] that projected a physician shortage in the United States by 1975, the Johnson Administration strongly supported legislation that subsidized medical schools to grow in number and size. Between 1965 and 1980, the number of medical schools increased from 80 to 126, and the annual number of graduates more than doubled to more than 15,000 per year.[7] Then, like a pendulum, expert opinion shifted with the publication of the Graduate Medical Education National Advisory Committee (GMENAC) report, the consequence of a panel convened by the Department of Health, Education, and Welfare.[8] This report, published in 1981, projected a nearly 25 percent surplus of physicians by the year 2000, and recommended significant reductions in the number of students enrolled in U.S. medical schools and the number of international medical graduates entering this country for advanced medical training. Again, as in the case of the report of the previous expert panel, the GMENAC recommendations dovetailed nicely with the policies of a concurrent Administration—in this case, efforts to pare down the domestic side of the federal budget.

As quickly as Congress had previously authorized and appropriated funds for medical school expansion in the mid-1960s, in 1981, Congress discontinued general federal support provided to medical schools for the education of new physicians. But, two years later, in the context of major changes in the system of Medicare reimbursement for hospital-related costs, Congress (out of concern for the effects of expected Medicare cuts on teaching hospitals) provided additional resources for the direct and indirect Medicare support of graduate medical education and teaching hospitals. This led to an explosive increase in the number of slots across medical specialties, many of which were filled by international medical graduates. Because the number of these slots ultimately determines the pool of newly licensed physicians, the effect of the new policy was to increase the size of the physician workforce through immigration—a result that ran counter to the recommendations of the GMENAC report.

In 1986, Congress established the first standing body to provide the federal government with an ongoing assessment of trends in the nation's physician workforce. COGME was charged also with advising and making recommendations on physician training and the financing of graduate medical education to Congress and the Secretary of Health and Human Services. COGME developed official reports and issue papers on the size and makeup of

5. Richard G. Frank and Sherry A. Glied, *Better But Not Well: Mental Health Policy in the United States since 1950* (Baltimore, Md.: Johns Hopkins University Press, 2006).
6. Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York: Oxford University Press, 1999).
7. *Ibid.*
8. Graduate Medical Education National Advisory Committee, Summary report, Vol. 1, April 1981.

the physician workforce in aggregate. In the early 1990s, it projected a surplus of 80,000 physicians by the end of the 20th century, with a serious maldistribution between a surplus of specialists and a deficit of primary care physicians.[9] It recommended that the number of GME places available nationwide not exceed the number of graduates of U.S. medical schools by more than 10 percent, and that 50 percent of the slots be reserved for primary care.[10]

Another federal agency also charged with advising the government on these issues, the Bureau of Health Professions in the Department of Health and Human Services, made a similar projection for an aggregate surplus of physicians by the year 2000. Throughout this period, there were a few dissenting voices from the "expert" consensus.[11] The major dissenting voice was that of Dr. Richard Cooper, who noted a strong historical correlation between the gross domestic product per capita and the demand for physician services, especially the services of specialists.[12] He projected no physician surplus at the beginning of the 21st century, and the facts on the ground appear to have proved him correct. In 2005, COGME completely reversed its previous position and recommended increasing the number of medical school slots to enable the country to avoid a serious shortage of 80,000 physicians by 2020.[13]

Obamacare: More of the Same

Given the dismal track record of the past 30 years of federally supported efforts to project a coherent picture of the adequacy of the aggregate physician workforce, it should be surprising that the Patient Protection and Affordable Care Act includes a new National Health Care Workforce Commission to provide recommendations to Congress and the Administration on national health workforce priorities, goals, policies and financing for education and training across all health care professions. The commission is required to provide *annual* reports to the Congress and the Administration on the current and projected supply and demand across the health care professions; the current and projected education and training capacity; the implications of federal policies affecting the workforce; the workforce needs of special populations and the underserved; and recommendations on loan repayment and scholarship programs for low-income and minority medical students. In a second separate *annual* report, the commission is to report on areas defined in the bill as "high priority" as well as others to be later determined.

In 2004, Dr. David Blumenthal, an official of the Obama Administration, wrote a compelling concluding sentence to a major health policy essay on physician supply that makes the whole concept of annual reports and the new commission seem absurd: "Increasing the frequency of assessment of the physician workforce will not necessarily lead to a more effective and rational workforce policy, something that seems likely to remain a critical, but elusive, goal for the profession and for the larger society."[14] Indeed, in this same article, Dr. Blumenthal argued that the states have the most relevant data on physician-to-population ratios, and that they are in the best position to address the need for additional medical school slots to expand enrollment and the creation of new medical schools. His conclusions can easily be amplified across all health care professions.

9. COGME summary of third report, "Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century," 1992.
10. COGME summary of fourth report, "Recommendations to Improve Access to Health Care Through Physician Workforce Reform," 1994.
11. Steven J. Jacobsen and Alfred A. Rimm, "The Projected Physician Surplus Reevaluated," *Health Affairs*, Vol. 6, No. 2 (1987), pp. 48–56, and William B. Schwartz, Frank A. Sloan, Daniel N. Mendelson, "Why There Will Be Little or No Physician Surplus Between Now and the Year 2000," *New England Journal of Medicine*, Vol. 318 (1988), pp. 892–897.
12. Richard A. Cooper, "Perspectives on the Physician Workforce to the Year 2020," *Journal of the American Medical Association*, Vol. 274 (1995), pp. 1534–1543.
13. COGME, "Physician Workforce Guidelines for the United States, 2000–2020," 16th Report, January 2005.
14. Blumenthal, "New Steam from an Old Cauldron—The Physician-Supply Debate," p. 1786.

Almost as an echo of federally funded social programs from the 1960s, the membership of the commission is spelled out to reflect input from the broader community while limiting the level of involvement by practitioners and educators from the health professions. Funds are provided to staff the commission, as well as a new National Center for Health Workforce Analysis within the Department of Health and Human Services. Again as in prior community-related health programs, funds are authorized for administration by HRSA[15] to provide one-year planning grants of $150,000 (with a 15 percent matching requirement by the states for a program that they have not requested) for partnerships between a state workforce investment board and a specified mix of higher education institutions and state education agencies. The authorization also includes up to two-year implementation grants with a 25 percent required state match to encourage these regional partnerships and to promote innovative workforce pathway activities. The latter program is authorized at a level of $150 million. In addition to these new developments, COGME will also continue to operate.

The paradox is that between 2000 and 2008, 18 separate reports, developed at the state level (or by medical societies, hospital associations, and research centers), have identified physician shortages by specialty and by region. Massachusetts's universal health care reform has exposed and amplified a shortage of primary care physicians in that state.[16] In terms of helping states identify and address workforce issues across all health care professions, would it not make more sense to provide them directly with resources rather than to reinvent approaches that have not worked in the past at the federal level? Why introduce an expensive new grant program requiring state matching funds for *federally* specified "partnerships"?[17]

Primary Care Provisions. In spite of multiple major initiatives by the federal government,[18] academic medical centers, and the official leadership of academic medicine, the percentage of graduating medical students entering primary care disciplines has plummeted.[19] Dissatisfaction among primary care physicians in practice has also reached alarming levels.[20] In its analysis of primary-care-related provisions of the new legislation, the Association of American Medical Colleges (AAMC) Center for Workforce Studies has identified a broad range of new or expanded initiatives, ostensibly designed to increase the primary care workforce. (Summarized in the text box).[21]

The time-limited conditional bonus in Medicare payments and the equalization of Medicare and Medicaid reimbursement for primary care physicians (no. 5 in the text box) might slow the exodus of these doctors from Medicare and Medicaid,[22] but too many of the specified program initiatives or enhancements are not likely to have a significant impact on the essential growth of the primary care workforce. When one adds the other multiple grant programs and other workforce-related initiatives

15. AAMC Center for Workforce Studies, "Health Care Reform and the Health Workforce: Workforce Provisions Included in the Patient Protection and Affordable Care Act," 2010.
16. John K. Iglehart, "Grassroots activism and the pursuit of an expanded physician supply," *New England Journal of Medicine*, Vol. 358, No. 16 (2008), pp. 1741–1749.
17. AAMC Center for Workforce Studies, "Health Care Reform and the Health Workforce."
18. Health Resources and Services Administration, at *http://www.hrsa.gov* (October 27, 2010).
19. Donna B. Jeffe, Alison J. Whelan, and Dorothy A. Andriole, "Primary Care Specialty Choices of United States Medical Graduates 1997–2006," *Academic Medicine*, Vol. 85, No. 6 (June 2010), pp. 947–958, at *http://journals.lww.com/academicmedicine/Fulltext/2010/06000/Primary_Care_Specialty_Choices_of_United_States.14.aspx* (October 27, 2010).
20. Val Willingham, "Half of Primary-Care Doctors in Survey Would Leave Medicine," CNNHealth.com, November 17, 2008, at *http://articles.cnn.com/2008-11-17/health/primary.care.doctors.study_1_primary-care-medicare-patients-medicaid-patients?_s=PM:HEALTH* (October 27, 2010).
21. AAMC Center for Workforce Studies, "Health Care Reform and the Health Workforce."
22. Todd Ackerman, "Texas Doctors Opting Out of Medicare at Alarming Rate," *The Houston Chronicle*, May 17, 2010, at *http://www.chron.com/disp/story.mpl/metropolitan/7009807.html* (October 27, 2010).

Summary of Primary Care Workforce Provisions in the Patient Protection and Affordable Care Act

1. National Health Service Corps and Related Community Health Centers Funding:
   a. Increases the authorized funding for the National Health Service Corps by 360 percent to $1.15 billion by 2015. (Title V Section 5207)
   b. Establishes a Community Health Centers Fund for the Community Health Centers and the National Health Service Corps authorizing HHS to provide additional increases of $1 billion in FY 2010 up to $3.6 billion in 2015 and $1.5 billion for construction and/or renovation of Community Health Centers. (Title X Sec. 10503 as modified by Sec. 2303 of P.L. 111-152)
   c. Authorizes funding to Federally Qualified Health Centers (community health centers that receive federal grants) from $3 billion in 2010 to $8 billion in 2015, along with enhanced reimbursement from Medicare and Medicaid and special protection from tort action. (Title X Section 10503)
2. Revises HRSA Health Professions Student Loan Program Guidelines:
   a. Revises the required length of service in primary care from service equal to the life of the loan to a total of 10 years, including the three-to-four-year period of graduate medical education for physicians. (Title V Section 5201)
   b. Reduces the non-compliance interest rate from 18 percent to 7 percent. (Title V Section 5201)
3. Miscellaneous initiatives:
   a. Primary Care Extension Program (grants from Agency for Health Research and Quality) to establish "state hubs" and local extension agencies to support local primary care physicians and implement Medical Homes programs and improve community health: $120 million for FY 2011 and 2012. (Title V Section 5405)
   b. Medical Homes under Medicare: pilot program by 2013, and Medicaid expansion with funding for planning grants. (Title III Section 3502)
   c. "Teaching Health Centers" for training primary care residents at Community Health Centers. Authorizes and appropriates such sums for direct and indirect costs of training residents up to $230 million for FY 2011 to FY 2015. (Title III Section 5508)
   d. Reauthorizes Area Health Education Centers (AHECs) to "maintain and improve" existing AHECs. (Title V Section 5403)
4. Advanced Practice Nursing:
   a. Nurse-managed clinics affiliated with a school, college, or department of nursing, Community Health Center, or independent nonprofit health or social services agency. The advanced-practice nurse must be a part of the executive management, and there must be a community advisory committee with a majority of members who are the clients of the clinic. (Title V Section 5208)
   b. Family nurse practitioner training programs to receive three-year grants through Federally Qualified Community Health Clinics and Nurse Managed Health Centers for one-year training program for primary care nurse practitioners. (Title III Section 10501)

(continued on next page)

Summary of Primary Care Workforce Provisions in the Patient Protection and Affordable Care Act (continued)

c. Nursing education loan repayment program. (Title V Section 5311)

d. Grants to five eligible hospitals to support the development or expansion of Advanced Practice Nurse Training programs under Medicare ($50 million per year from 2012 to 2015). (Title V Section 5208)

5. Incentive payments to providers:

a. Bonus payments of 10 percent for primary care physicians whose Medicare charges for office, nursing home care, and home visits comprise 60 percent of their total Medicare charges. The bonus would run through 2016. (Title V Section 5501)

b. Increases Medicaid payments to primary care physicians to no less than 100 percent of Medicare rate in 2013 and 2014 with the costs covered by the federal government. (Sec. 1202 of H.R. 4872)

identified in the legislation by the AAMC Center for Workforce Studies, the overall effort reads like a combination of earmarks, good intentions, and naiveté. It is a scattershot approach that repeats many of the mistakes of the past, and, like the past, will make any program evaluation impossible.

The PPACA re-authorizes the Area Health Education Center (AHEC) program, which funds centers across the country. These AHECs, in turn, fund a national organization, the National Area Health Education Center Organization (NAO), that serves as an advocacy arm that supports ongoing AHEC funding by Congress. As early as 1977, a report by the Carnegie Council found "no hard statistical data…to measure the actual effect of the AHEC program on attracting or retaining health personnel for practice in underdeveloped areas."[23] What remains unclear is the added value of AHEC in terms of activities that would not or could not have been performed otherwise, or whether any specific activities had more than minimal impact. In terms of attracting medical students to public service and primary care (one of its core missions), it is hard to find evidence that the program has made a difference. Indeed, if one takes a more granular look at the proposals specific to primary care in the new law, it begins to read like a bad joke.

As noted in the text box, the PPACA also provides huge increases for the National Health Service Corps and the Community Health Centers that serve as training and employment sites. Yet, the greatest problem that these Community Health Centers (CHCs) face is an inability to recruit an adequate number of primary care physicians and other health professionals.[24] At the end of June 2010, the HRSA reported 5,636 active providers and 9,141 open positions at CHCs.[25] On that same date, there were vacancies specifically for 3,620 primary care physicians (PCPs), more than the 3,197 PCPs listed as active.

It is not at all clear that more funding will address the recruitment problem. In a survey of the shortage of medical personnel at community health centers, researchers found that physician recruitment in these settings was heavily dependent on National Health Service Corps scholarships, loan repayment

23. Daniel J. Zwick, Robert Walkington, Daniel R. Smith, and George Stiles, "A Report on the National AHEC Program," *Public Health Reports*, Vol. 92, No. 2 (1977), pp. 108–120.

24. Roger A. Rosenblatt, Holly A. Andrilla, Thomas Curtin, and L. Gary Hart, "Shortages of Medical Personnel at Community Health Centers," *Journal of the American Medical Association*, Vol. 295 (2006), pp. 1042–1049, at *http://jama.ama-assn.org/cgi/content/abstract/295/9/1042* (October 27, 2010).

25. Health Resources and Services Administration.

programs, and international medical graduates with J-1 visas.[26] For rural Community Health Centers, which have had the greatest difficulty filling positions, cultural isolation, poor quality schools and housing, and lack of spousal job opportunities were major barriers to effective recruitment and retention. If there were to be an expansion of the National Health Service Corps, Congress would need to find ways of retaining the individuals beyond their service commitment since many physicians currently abandon the Community Health Centers at the end of their service obligation.[27]

So how does the PPACA deal with the retention problem? As noted in the text box, it changes the period of required service from the life of the loan to a total of 10 years, which is usually shorter and includes the three-to-four-year period of post-medical school training and it reduces the non-compliance interest rate penalty from 18 percent to 7 percent. In essence, it makes it easier for loan recipients to opt out of primary care service when early departure and non-retention are already a known problem. Moreover, it expands the Community Health Center program at the same time as it provides universal coverage through health insurance mandates and an increase in the Medicaid population. It sees the CHCs and their roles as "Teaching Health Centers" as the best way to encourage medical students' interest in primary care, even as previous efforts of this type have failed to reverse the decline in primary care applicants over the past two decades. Moreover, it is unclear if the newly insured will opt to be treated in Community Health Centers or in independent group or individual practice, or if these preferences will vary by state and district (rural/urban/suburban). If there is one thing that has already been learned from the experience with universal coverage in Massachusetts, it is that it will be difficult to affect the preferences of the newly insured in relationship to their choice of venue for health care. Massachusetts has been unable to reduce the use of emergency department visits for non-emergency care.[28]

To its credit, the PPACA does reference the need to increase the pool of advance-practice nursing as part of the effort to expand the primary care workforce, but it ignores the possible role of physician's assistants, who were probably not as well represented in the lobbying efforts over the legislation. The legislation proposes to support training and scholarship aid to increase the pool of advanced-practice nurses. The proposed set-asides for nurse-managed clinics and for grants to five eligible hospitals to develop or expand their training programs for advanced-practice nurses ($50 million per year from Medicare) reads like an earmark rather than a well-developed and considered policy initiative. The most critical area of need for advanced-practice nurses is in primary care, which is already being addressed in some states by nurse practitioners. States differ in terms of permissible scope of practice. While all states allow nurse practitioners some degree of prescribing privilege, only 12 states have granted nurses the autonomy to prescribe medications independent of physician involvement or oversight.[29]

There is empirical support for a policy that fosters choice and diversity in the clinical practice environment. With the end of dedicated federal funding of community mental health centers in 1981 (and especially since the early 1990s), researchers found that the rate of inflation for behavioral health services has generally followed the overall inflation rate rather than the much higher health care inflation rate.[30] Researchers

26. Rosenblatt, Andrilla, Curtin, and Hart, "Shortages of Medical Personnel at Community Health Centers."
27. Christopher B. Forrest, "Strengthening Primary Care to Bolster the Health Care Safety Net," *Journal of the American Medical Association*, Vol. 295 (2006), pp. 1062–1064, at *http://jama.ama-assn.org/cgi/content/extract/295/9/1062* (October 27, 2010).
28. Liz Kowalczyk, "Emergency Room Visits Grow in Mass.: New Insurance Law Did Not Reduce the Number of Users," *The Boston Globe*, July 4, 2010, at *http://www.boston.com/news/health/articles/2010/07/04/emergency_room_visits_grow_in_mass* (October 27, 2010).
29. "AMA Scope of Practice Data Series: Nurse Practitioners," October 2009, at *http://www.aanp.org/AANPCMS2/publicpages/08-0424%20SOP%20Nurse%20Revised%2010-09.pdf* (October 27, 2010).
30. Frank and Glied, *Better But Not Well*.

Richard Frank of Harvard University and Sherry Glied of Columbia University attributed this trend in part to the diversification of the workforce with medication management by primary care physicians, nurse practitioners, and psychiatrists; and, non-pharmacological treatments provided by a broad array of practitioners licensed as therapists by the separate states. Other factors include a diversification of care venues (partial hospital care as a substitute for long-term hospitalization) and managed behavioral health care carve-outs which have kept a tight lid on costs while allowing more people to receive care. Might there be lesson in this for the rest of health care in the context of emerging universal coverage?

State licensing of all health care professionals and defining scope of practice as well as state oversight of venues of care and health insurance products should serve to enable change. States have also applied lessons from the private sector to their management of Medicaid-funded care for the mentally ill—often contracting with managed behavioral health organizations experienced in managing the care of individuals with severe and chronic mental illness. While there is no data to suggest that there has been deterioration of care and outcomes in the behavioral health system that has emerged, the system is not perfect.[31] There are too many disconnects in the care provided to patients by different providers who have too little communication with each other regarding the status of the patient whose care they are supposed to share. This, too, could become a problem in a larger health care system of separate and autonomous independent practitioners. But, if problems emerge, they are more likely to be identified at the local level—not by a federal agency.

Given the current trends in physician-based primary care, the development of a robust cadre of advanced-practice primary care nurses (and physician's assistants) should become a major priority, especially in states that already face a crisis in primary care. A large expansion in the primary care nurse practitioner and physician's assistant workforce can be achieved at lower cost and in a shorter timeframe than a comparable increase in the number of primary care physicians. If the example from the behavioral health sector is applicable to primary care, then a rapid increase in the non-physician workforce might actually contribute to bending the health care inflation curve.

Once again, all of the tools in the state-based toolbox—from oversight of higher education and professional licensing, scope of practice, and rules governing health insurance—are relevant to this solution. With the possible exception of the loan repayment program, the federal pump-priming proposed in the PPACA does not match what the states are already empowered to do to expand the pool of advanced-practice primary care nurses and physician's assistants.

The nursing profession has already tightened the educational requirements related to advanced-practice nursing. With greater professional responsibility should come greater individual accountability through a rigorous process of credentialing and periodic mandatory re-credentialing managed by the profession and regulated through state licensing agencies.

While there are a number of promising outcome studies that suggest high degrees of satisfaction with the care that patients have received from advanced-practice primary care nurses,[32] additional studies might be helpful in convincing more states to lower the barriers to nurses as first-line primary care clinicians. While being sensitive to the unique and common-practice elements of each profession, a more granular research approach could compare the relative effectiveness and cost effectiveness of primary care physicians and advanced-practice primary care nurses (and physician's assistants) in health screening and health promotion activities and in the care

31. Roger E. Meyer, "Is the Glass Really Half Full?" *Health Affairs*, Vol. 26 No. 2 (2007), pp. 587–589, at *http://content.healthaffairs.org/cgi/content/full/26/2/587* (October 27, 2010).
32. Gail L. Ingersoll, "Outcomes Evaluation and Performance Improvement: An Integrative Review of Research on Advanced Practice Nursing," in *Advanced Practice Nursing: An Integrative Approach*, 4th Edition, Ann B. Hamric, Judith A. Spross, and Charlene M. Hanson, eds. (St. Louis, Mo.: Elsevier, 2009), pp. 681–732.

and management of various chronic illnesses. The results of additional well-designed health policy studies that compare the services provided and the outcomes of patients in demographically matched jurisdictions from states that differ in scope of approved independent nurse practice might be of special value. Rather than forcing taxpayers to fund the multiple grant programs enumerated in the Patient Protection and Affordable Care Act, Congress would better serve its constituents if federal resources, such as the Agency for Healthcare Research and Quality, the National Institutes of Health, or even the Centers for Medicare and Medicaid Services, supported health policy studies to help states assess policies that discourage the broader use of well-trained advanced-practice primary care nurses and physician's assistants.

What Policymakers Should Do

Both state and federal policymakers need to change direction.

1. **Congress should not appropriate funds for the proposed National Health Care Workforce Commission and the associated Center for Workforce Analysis.** Instead, states should prepare to take the lead in resolving their own most difficult workforce issues.
2. **Congress should convert existing and projected workforce programs into block-grant workforce funding to the states.** Congress should review the workforce related (and some other) programs funded by the HRSA (see textbox) and convert most or all of these programs into block grants to the states to strengthen the health care workforce. Medicare funding of graduate medical education should also be considered for inclusion in the block grants to the states, which may choose to target training in specific primary care or specialty care disciplines for expansion or contraction based on local need.
3. **States should focus on primary care.** States should use their existing oversight authority to expand the pool of licensed primary care health care providers, including the scope of practice privileges for advanced-practice primary care nurses and physician's assistants. States should consider the optimal venues and provider mix for the provision of primary care services to different age groups, and for patients with different chronic health conditions under Medicaid and among the newly insured. This should result in some states placing greater emphasis on Community Health Clinics, some states making no change or decreasing the emphasis on Community Health Clinics, and some states preferring alternative venues for the delivery of primary care.
4. **States should get serious about tort reform.** States should also implement tort reform to recruit and retain specialists whose practices are being threatened by confiscatory malpractice premiums.

Conclusion

The Patient Protection and Affordable Care Act emphasizes a federal agency–based strategy for assessing the needs across the full span of health care disciplines, a strategy that has failed repeatedly to project the physician workforce requirements since the mid-1980s. The proposed short-term grant funding of a broad array of well-meaning program initiatives designed from the top down by federal officials follows a failed pattern first developed by the Departments of Health, Education and Welfare, Housing and Urban Development, and the Office of Economic Opportunity in the 1960s. Short-term grant funding of multiple initiatives with overlapping goals makes it impossible to assess the impact of any single program, or of the entire enterprise. Most important, the tools to accurately identify shortages and surpluses of personnel across the health care professions, and to address solutions through oversight of higher education, licensing, defining scope of practice, insurance regulation, and tort reform, all exist at the state (and not the federal) level.

Rather than repeat the failed top-down approach, Congress should convert workforce-related programs supported by the Health Resources and Service Administration into block grants to the states and should also consider moving GME funding from Medicare into the same block grant program. When the block grant approach was used in 1981 during the Reagan Administration for programs

supported by the Alcohol, Drug Abuse and Mental Health Administration, opponents predicted a major disaster. Instead, the states and the private sector led the way in creating innovative solutions that bent the inflation curve downward for behavioral health services to insured and Medicaid populations.

Real health care reform requires innovation. It cannot emerge from a flawed legislative process. Genuine innovations that improve care and control cost have emerged at the state and local levels. These include developments, such as outpatient surgical centers, assisted-living programs as alternatives to nursing homes for the elderly, and private long-term care insurance which can (if applied more broadly) reduce the use of Medicaid to support the care of the elderly in nursing homes and other costly venues. These innovations emerged in spite of Medicare and Medicaid. They developed under state purview. Mechanisms, including new insurance products and arrangements, need to be strengthened in a reformed health care system. On the issues related to the health care workforce, the Patient Protection and Affordable Care Act needlessly adds to the deficit with costly new initiatives that ignore history. It also ignores the vital and creative role of federalism—the proper boundaries of federal and state responsibilities—so brilliantly articulated by America's Founders.

—Roger E. Meyer, M.D., is a former Dean and Vice President of Medical Affairs at George Washington University, and currently President and CEO of Best Practice Project Management, Inc.