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A Faster, Better, Cheaper Path To Filling The Doctor Shortage



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Recent headlines at RealClearPolitics tell the story: [Health Law Amplifies Primary Care Doctor Shortage](#) and [Medicaid Growth May Aggravate Doctor Shortage](#). And a recent companion piece at RealClearPolicy reminds us the problem is not limited to primary care doctors: [The Physician Specialty Shortage](#).

How big is the problem? The most widely cited figures come from the Association of American Medical Colleges' Center for Workforce Studies which updated its estimates in 2010 to account for the impacts of the Affordable Care Act. That report projected an overall shortage of 62,900 physicians in 2015, showing that it would more than double to 130,600 by 2025. Even though much of the press attention has been on primary care physicians[1], the current shortage of specialty physicians actually is slightly larger in 2015 (33,100) than for primary care physicians (29,800). Given the enormous amount of time (7-10 years [2]) and money (which exceeds \$1 million for some specialties [3]) to train just one physician, filling these gaps hypothetically would require a huge amount of time and money.

A recent [report](#) I've completed on the state of North Carolina shows that a much faster, better and cheaper path is available to address this problem: removing unnecessary restrictions on the scope of practice for advanced practice nurses (APRNs). APRNs include nurse practitioners, nurse midwives (CNMs), nurse anesthetists (CRNAs) and clinical nurse specialists (CNSs). North Carolina is among the [31 states that have yet to legislatively authorize "full \[scope of\] practice" status for all nurse practitioners](#) (and there are similar regulatory barriers that stand in the way of CNMs, CRNAs, and CNSs from being able to practice to the full extent of their training.

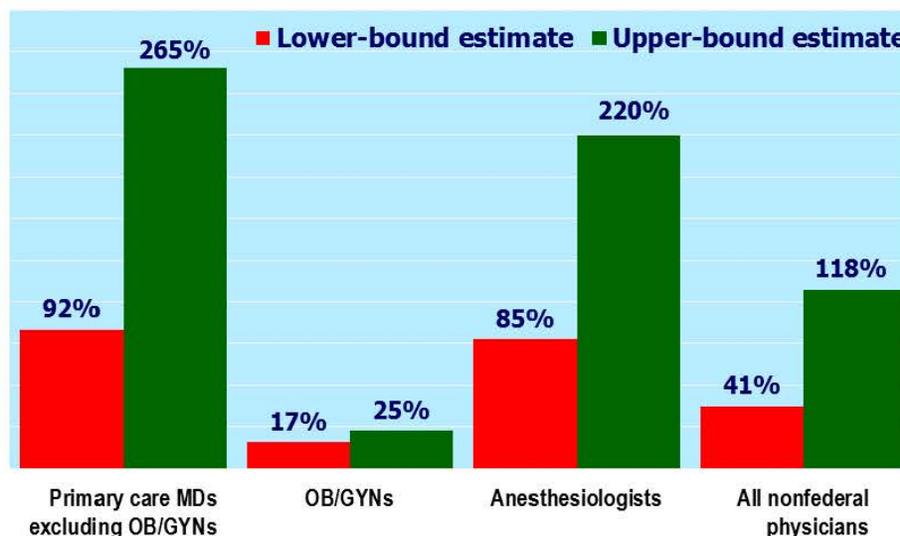
The result of such laws is that the time of both physicians and APRNs that might otherwise have gone into patient care ends up being squandered on unnecessary regulatory compliance/supervision. Thus, while our findings certainly are important for North Carolina, many other states with similar

restrictive regulations would benefit in a comparable fashion if they would adopt the least restrictive scope of practice rules now in operation in states such as Arizona, Montana, New Mexico and Utah.

Potential Impact on Physician Shortages

We calculated the potential increase in the number APRNs practicing in North Carolina by using a previous study that had compared how quickly the number of NPs had grown in states with the least restrictive scope of practice regulations to those in states (like NC) with the most restrictive. We concluded that between 2012 and 2019, the number of APRNs would increase an additional 24.4% were North Carolina to adopt the least restrictive rules for APRNs. We then estimated how much the projected shortage of physicians potentially might be reduced by this increase in APRN supply. As shown in the figure, the results were quite dramatic.

Potential Impact on Physician Shortages of Less Restrictive Regulation of APRNs in North Carolina



Source: Duke University, Center for Health Policy and Inequalities Research

Less restrictive regulation of APRNs would result in a net increase of 1,744 full-time-equivalent APRNs relative to the 2012 supply. Taking into account the extent to which APRNs can reduce the need for physicians either directly (by substituting for doctors to the extent their training allows or diverting physician supervision time into patient care) or indirectly (e.g., by reducing the need for hospitalization and the companion physician care that otherwise would be needed), we estimate the impact on the projected shortage of physicians in NC as follows:

- It could eliminate the shortage of OB/GYNs while reducing the shortage of non-OB/GYN primary care doctors by 83%.

- It could eliminate at least 85% of the projected shortage of anesthesiologists.
- It could decrease the overall shortage of nonfederal physicians by 41%.

In short, these dramatic reductions in our state's doctor shortage could be achieved far faster and less expensively than trying to solve the problem through an increase in the number of physicians coming out of the medical school pipeline.

A Side Benefit: Faster Economic Growth

While the economy is certainly improving, there continue to be concerns about the relatively sluggish pace of GDP growth relative to prior decades. Our study also calculated the potential economic benefits of expanded APRN use. Modernizing regulation of APRNs would result in the following economic impacts (including direct, indirect and induced effects on the broader economy):

- At least 3,800 new jobs (possibly up to 7,128)
- An annual increase in economic output of at least \$477 million (possibly up to \$883 million)
- This expansion also would produce annual health system cost savings ranging from \$433 million to \$4.3 billion.

But What About Quality?

We also reviewed a sizable body of evidence related to whether there was any difference in quality of care when it was provided by APRNs rather than physicians. There is extensive empirical evidence that APRN practice outcomes are at least equivalent to those of physicians to which they are compared. And on some metrics, such as patient satisfaction, some studies have found APRN care is actually better. From a value-for-money perspective, it is difficult to argue that North Carolinians would be better served by a health care system that spends more to achieve the same (or slightly worse) outcomes when a lower cost alternative is readily available. Moreover, especially when there is a shortage of physicians, it makes little sense to further divert doctors from patient care by imposing burdensome physician supervision requirements that other states have eliminated without any empirically demonstrable adverse effects on quality of care. Less restrictive regulation of APRNs offers the prospect of providing North Carolina residents better access to care of equivalent or better quality even as the health system sheds some avoidable costs (e.g., hospitalizations) in the process. It is rare that a health policy change offers gains across all three major dimensions of health system performance. These lessons are not unique to North Carolina. Plenty of other states could benefit from considering the same policy changes.

READ CHRIS' BOOK, *The American Health Economy Illustrated* (AEI Press, 2012), available at Amazon and other major retailers. With generous support from the National Research Initiative at the [American Enterprise Institute](#), an on-line [version](#) complete with downloadable Powerpoint slides and companion spreadsheets has been made available through the Medical Industry Leadership Institute's Open Education Hub.

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INVESTORS' NOTE: The biggest publicly-traded players in Obamacare's health insurance exchanges are Aetna (NYSE:[AET](#)), Humana (NYSE:[HUM](#)), Cigna (NYSE:[CI](#)), Molina (NYSE:[MOH](#)), Anthem (NYSE:[ANTM](#)), and Centene (NYSE:[CNC](#)), in order of the number of uninsured exchange-eligible Americans for whom their plans are available.

Footnotes

[1] In its shortage studies, AAMC [defines](#) primary care doctors as those physicians whose specialty is listed as internal medicine, family medicine or pediatrics in the AMA Masterfile.

[2] Physicians attend medical school for 4 years and then spend another 3-7 years in residency depending on what specialty(ies) they pursue.

[3] A careful [study](#) by The Lewin Group found that the cost to train a single anesthesiologist (2008 dollars) was \$1.03 million inclusive of \$624,000 in costs to get through medical school and first-year residency plus another \$460,000 for 3 additional years of medical residency ([Table 10](#)). What's remarkable is that these figures subtract \$775,000 to account for the productivity of anesthesia students during their graduate education residency. The parallel figure for Certified Registered Nurse Anesthetists (CRNAs) is \$108,000. In both cases I have subtracted the estimated \$53,700 in costs for four years of college since most people pursuing medical degrees would have gotten such an education even if they never ended up in the medical field.