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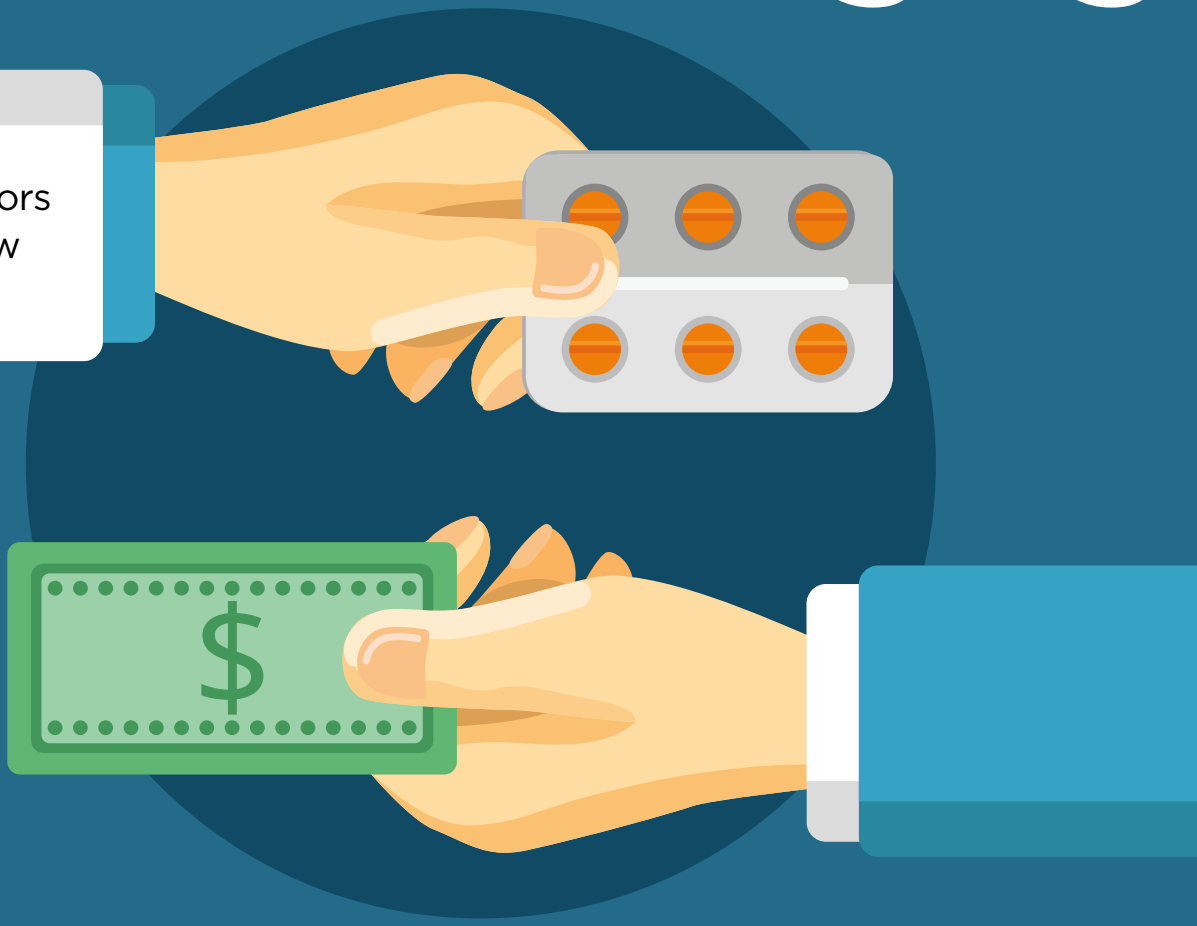
Drug Price Gouging

As Drug Prices Skyrocket, Legislators Take Aim With New Transparency Bills



Changing Demographics of the Physician Workforce

New Blood Pressure Guidelines

An Update on the Exchanges

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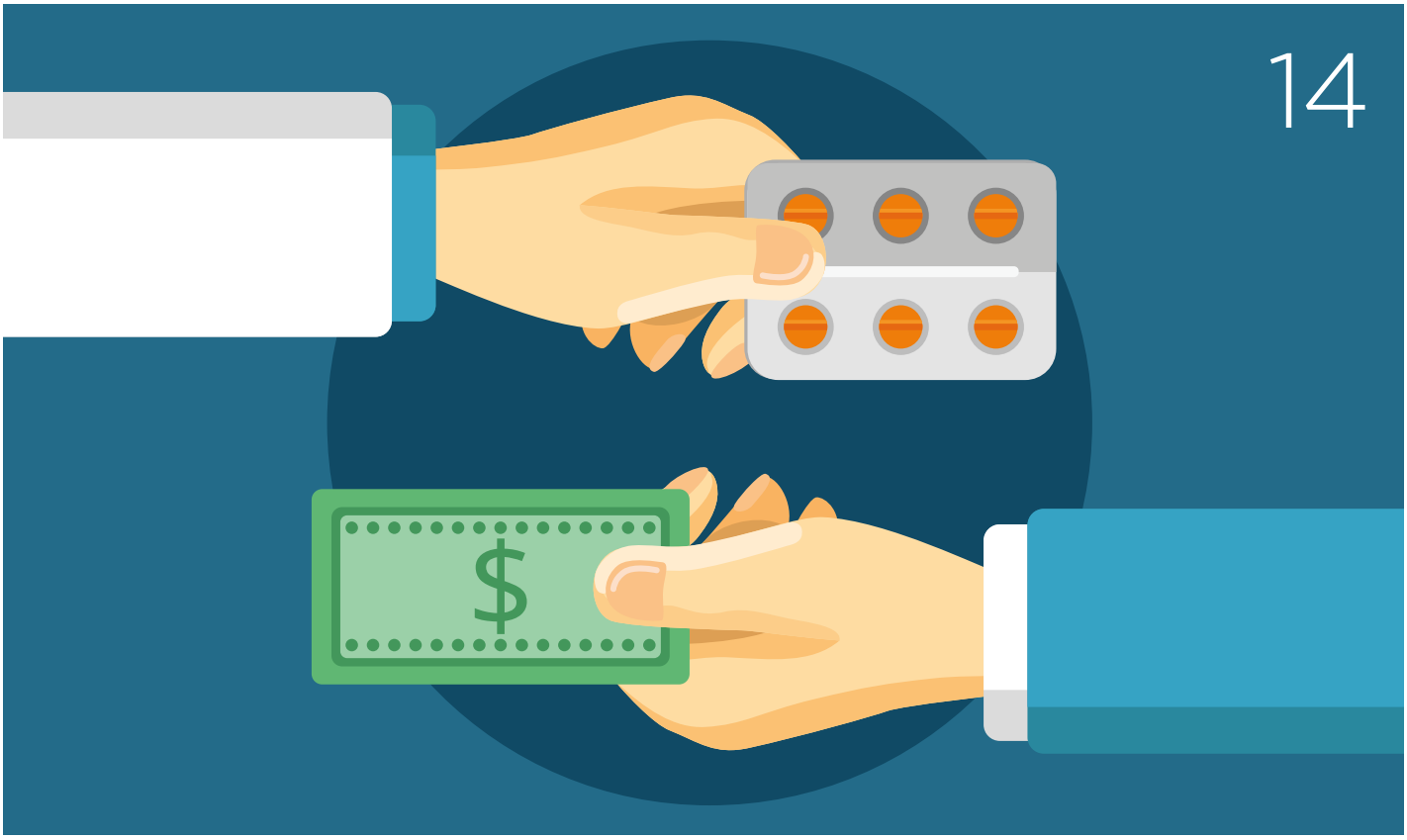

FEATURES

Changing Demographics of the Physician Workforce

Forces driving demand for healthcare services years in the making

By Robert James Cimasi, MHA, and Todd A. Zigrang, MBA, MHA

EVEN AS RECENTLY as the post-World War II era of the 1950s, in many areas of the country, it was not atypical that when an injury or sudden illness required a response by emergency services, the dispatcher would sound the community sirens, signaling the volunteer firemen on duty to radio ahead from their emergency vehicle to a small, rural hospital, which would then alert one of the few physicians in the community to rush to the hospital to provide emergency care. In the more urban areas, with a greater supply of trained healthcare professionals, access to care was still based, to a great degree, on the ability of patients and their families to pay, or on charity care. This was a time in U.S. history when *Marcus Welby, MD*, was not only a popular family television drama, but was also a reasonable characterization of how healthcare services were perceived to be delivered by physicians throughout much of the country.

Following World War II, the U.S. healthcare delivery system saw the rapid advent of new medical technologies, which changed how healthcare was delivered, and resulted in higher levels of health and an increased life expectancy. During that 67-year period, the demographics of the U.S. population significantly changed—the U.S. population has nearly doubled and has become more racially and ethnically diverse; the population has become more urbanized; and, the average life expectancy has increased, along with the incidence and prevalence of chronic disease. The Baby Boom years from the late 1940s to the early 1960s saw a record number of births, with the proportion of the U.S. population over age 65 increasing from 8.1% in 1950 to approximately 15% in 2016. The trend is expected to continue as the Baby Boomer generation ages.

Aging and Specialization

This increased life expectancy, and the subsequent "graying" of the Baby Boomer population, with the accompanying rise in the incidence and prevalence of diseases, conditions, and injuries for which the elderly are more at risk, creates the conditions for a "demographic time bomb," which is expected to continue driving demand for healthcare services. Also among the driving forces of U.S. healthcare industry trends are the supply and distribution of various types and multiple levels of healthcare professionals who work within a dynamic framework of myriad competing interests to meet the growing needs of a changing population. As a result of technological and medical advances, specialized medicine flourished and has changed the nature of the physician-patient relationship.

One response to the past and present surge in demand associated with these medical advances is the growth in the physician population. The number of physicians increased from 393,742 in 1975 to 1,045,910 in 2013, and the number of physicians per 100,000 individuals increased from 182 to 331 over the same period. This increase in the number of physicians over the past several decades was driven in part by the rapid increase in government healthcare funding, starting with the 1946 passage of the Hill-Burton Act, which marked the beginning of over four decades of federally funded health policy planning.

Despite these changing workforce trends, a disproportionate number of physicians are expected to retire or reduce their workload, far outpacing the number of new medical graduates, and the expected growth in demand. The current physician manpower shortage will continue to worsen.

Against this backdrop, the healthcare workforce has increasingly diversified. The healthcare workforce is comprised of more than 18 million individuals, with fewer than one million being professionally active physicians. This article will examine the diversification, specialization, and collaboration of physicians that has increased and expanded to meet the compounding demand from the changing patient population.

Diversity and Disparity

As noted above, the demographics of the U.S. physician workforce are shifting, and consequently becoming more diverse. In addition to the increasing number of female physicians, the proportion of physicians from minority backgrounds has also increased. Despite this increasing ethnic and racial diversity in the medical profession, it is important to note that physician demographics do not mirror the U.S. population. Minority physicians are underrepresented in comparison to the larger patient population, especially those in underserved areas, where physicians are needed the most.

There has been a concerted effort over the past several years by both lawmakers and stakeholders in the industry to diversify the physician workforce. The Association of American Medical Colleges (AAMC) noted in its briefing on healthcare policy priorities the importance of medical schools and teaching hospitals diversifying the physician population ethnically, racially, and culturally to align with the

needs of underserved populations in order to increase cultural awareness and eliminate health disparities. The AAMC reasons that increased diversity in the physician workforce (wherein the makeup of the physician population mirrors the patient population) may lead to higher quality care, better access to care, and increased medical innovation.

Additionally, programs such as the Health Careers Opportunity Program (HCOP) and Centers of Excellence (COE) prepare minority and disadvantaged students for health-related careers. HCOP is a K-16 pipeline program that collaborates with community organizations to improve recruitment and retention in the healthcare workforce. COE provides an educational pipeline too, but it also promotes research on minority health. Medical schools are also prioritizing physician workforce diversity; in a 2015 survey of all medical school deans, 84% of respondents reported that their admissions process included specific programs/policies that focused on recruiting those of diverse backgrounds, including those from disadvantaged backgrounds, rural/underserved communities, and underrepresented minorities.

Retirement and Lifestyle

The percentage of physicians older than 55 has continually increased over the past several years, and currently comprises over 40% of the physician population. Of significant concern in the healthcare industry is that the number of physicians who will be retiring in the coming decade is not being matched by new entrants to the market, since only 13.9% of physicians are age 35 or younger, and it is projected that 115,000 physicians will leave the workforce between 2016 and 2019, while only 81,000 physicians will enter the workforce, resulting in a projected shortage of up to 90,400 physicians by 2025. Moreover, the younger generation of physicians is working fewer hours than their predecessors, exacerbating the already-acute physician manpower shortage.

This deficiency of the physician workforce was, in part, the result of the implementation of recommendations made in the 1980 report by the Graduate Medical Education National Advisory Committee (GMENAC), that U.S. medical school enrollment be reduced due to a perceived oversupply of physicians. In contrast, by the 1990s, an undersupply of physicians in primary care, internal medicine, and pediatrics had developed.

Primary Care and Parallel Services

Several recent federal and state initiatives specifically address the downturn in primary care physicians (PCPs) entering the physician workforce and counteract current trends that favor specialist care (higher reimbursement yields). One of the main aims of the ACA is to increase access to preventative care, in part by increasing the number of PCPs in the market. To incentivize physicians to focus in primary care, the ACA (and subsequent provisions) increases reimbursement to PCPs to incentivize physicians who were concerned about compensation amounts relative to educational debt and offers tuition forgiveness to those PCPs who practice in rural areas where access is traditionally lower.

Another initiative to address this current physician manpower shortage is the vertical expansion in the role of the non-physician workforce to provide services that support, supplement, and parallel physician services. For example, in 2014, Missouri became the first state to create a new category of licensed professionals—'assistant physicians.'" In addition, non-physician providers (NPPs), such as physician assistants and nurse practitioners, are afforded a significant level of autonomy within their scope of practice, which authorizes them to act, not only incident-to, but also in lieu of physicians, under certain conditions, and for the provision of previously determined services.

The degree of practice autonomy typically differs from state to state and for each type of NPP. In the next few years, the NPP population is expected to continue to grow in scope and volume. From 1987 to 1997 alone, the number of patients treated by NPPs grew to 1.4 times the original amount. According to a 2009 Office of Inspector General (OIG) report, 51% of Medicare-billed physician services that exceeded a 24-hour workday were performed by qualified NPPs (those who may have been performing "incident to" services). Further, the services provided by NPPs (both qualified and non-qualified) over a three-month period totaled approximately $85 million in Medicare claims.

A Demographic Time Bomb

The current and impending physician manpower shortage, declining reimbursement rates, and generational change in quality of life expectations have fueled the demand for physician manpower relief. In response, the healthcare workforce continues to diversify, beyond the historical horizontal expansion of specialty and subspecialty areas of medical expertise. Additionally, a greater number of physicians are eschewing the traditional *Marcus Welby, MD* type of independent, autonomous physician practice and accepting some type of employment model, whether with a hospital or a medical group. Government programs have tried to ameliorate both supply and distribution (compounded by the actions taken pursuant to the 1980 GMENAC report). Despite these numerous initiatives, to date, the shortage is projected to continue at an increasing rate, especially in primary care.

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