HEALTH POLICY

Physicians, the Affordable Care Act, and Primary Care: Disruptive Change or Business as Usual?

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The Patient Protection and Affordable Care Act[1] (ACA) presages disruptive change in primary care delivery. With expanded access to primary care for millions of new patients, physicians and policymakers face increased pressure to solve the perennial shortage of primary care practitioners. Despite the controversy surrounding its enactment, the ACA should motivate organized medicine to take the lead in shaping new strategies for meeting the nation's primary care needs. In this commentary, we argue that physicians should take the lead in developing policies to address the primary care shortage. First, physicians and medical professional organizations should abandon their long-standing opposition to non-physician practitioners (NPPs) as primary care providers. Second, physicians should re-imagine how primary care is delivered, including shifting routine care to NPPs while retaining responsibility for complex patients and oversight of the new primary care arrangements. Third, the ACA's focus on wellness and prevention creates opportunities for physicians to integrate population health into primary care practice.

KEY WORDS: insurance; healthcare; Patient Protection and Affordable Care Act (ACA); primary care; NPP.
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INTRODUCTION

The Patient Protection and Affordable Care Act[1] (ACA) presages disruptive change in primary care delivery. With expanded access to primary care for millions of new patients, physicians and policymakers face increased pressure to solve the perennial shortage of primary care practitioners. Despite the controversy surrounding its enactment, the ACA should motivate physicians and professional medical associations (physicians)—including specialty and state medical societies—to take the lead in shaping new strategies for meeting the nation's primary care needs.

To date, physicians have been remarkably successful in rebuffing changes to primary care, such as supporting expanded state scope of practice laws that would open primary care practice to non-physician practitioners (NPPs—i.e., Nurse Practitioners and Physician Assistants). Instead of continuing to fight against NPPs as primary care practitioners and similar innovations, physicians should take advantage of the post-ACA environment to create a new primary care role that would integrate population health into primary care practice. The alternative is not business as usual; absent medical leadership, state legislatures and regulators are likely to impose solutions that may not be favorable to primary care physicians.[2]

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PHYSICIAN SUPPLY AND THE DEMAND FOR PRIMARY CARE

Historically, the United States has fluctuated between projected physician shortfalls and surpluses. With the passage of the ACA, the nation will face a physician shortage in the coming decades. The Association of American Medical Colleges (AAMC) estimates a 124,000–159,000 physician deficit across all specialties by 2025. By 2020, the primary care scarcity will reach 45,000 physicians.[3]

Several demographic factors will exacerbate the looming physician shortage. First, the nation's population will continue to grow. Between 2006 and 2025, the U.S. Census Bureau projects population growth of some 50 million.[3,4] Second, the ACA provides access to health insurance for approximately 32 million Americans.[3] Third, the percentage of physicians choosing to enter the field of general internal medicine is declining, while those choosing to exit the field is rising.[5] Fourth, attempts to expand the supply of primary care physicians have had only incremental success. These demographic changes will result in significantly increased demand for primary care, without the corresponding resources to meet the demand.[3]

Long before the ACA, addressing the primary care physician shortage was a key policy concern among both state and federal policymakers. In 2006, for example, Massachusetts enacted health reforms expanding health insurance to most state residents. But the number of primary care providers accepting new patients dropped drastically,[6] and the average wait time for a new appointment increased considerably,[6] at least in part because the reform did not allocate adequate funding for primary care. The combination of higher demand for primary care services and inadequate supply engendered frustration among patients and practitioners alike. Consequently, a concept that started out as a positive—granting access to all residents—had the opposite effect.[6]

While imbalances in supply and demand characterize the physician shortage, other confounding factors, including inadequate primary care reimbursement rates, the income disparities between specialists and primary care practitioners and inadequate time to spend with patients affect the willingness of medical

students to enter into general internal medicine. Even though not a panacea, expanding the role of NPPs as primary care practitioners is probably the most immediate strategy for alleviating the primary care shortage. Other potential solutions include forming Accountable Care Organizations, patient-centered medical homes, ending the Medicare freeze on support for medical training, and incentives to medical students to begin careers in primary care.[3] Certainly, these are important approaches, but are unlikely to meet the increasing demand for primary care.

THE ROLE OF NPPs

Numerous studies have been conducted to understand the ability of NPPs to act as either supplements to or substitutes for primary care physicians.[7–14] Because of the breadth of primary care practice, the studies assessed NPPs' roles in chronic disease management, urgent care, pediatrics, women's health, adult medicine, and first response/ongoing care. When examining the literature, almost all studies have reached a similar, yet resounding conclusion—the quality of primary care is comparable between physicians and NPPs.[7–13]

In particular, consistent research findings have included the lack of appreciable differences in patient health outcomes, self-reported health status, treatment options, utilization of services, and resource use.[13] Studies also demonstrate that nurse-led care has consistently resulted in detailed assessments, thorough communications, and higher patient satisfaction. In some cases, nurse-led care has yielded improvements in quality of life, health status, and survival rates.

Beyond general primary care capacity, studies and reviews have recognized specific benefits from NPPs' care. First, NPPs emphasize communications and health education. For example, NPPs generally conduct longer consultations, provide more detailed health information, and offer advice on self-care and management.[7–11] Based on their education and training, NPPs are more likely to concentrate on delivering patient-centric care through open communication and health promotion. Given the ACA's emphasis on prevention and wellness, these attributes will be highly valued to meet the Act's objectives.

Second, patients often rate NPPs high on patient satisfaction surveys. In adult medicine and pediatric settings, patients were significantly more likely to be satisfied with NPP interaction than with physician interaction on visits.[14] To be fair, studies also show that patients are satisfied with their primary care physicians.[8,9,13,14]

Nonetheless, a legitimate question is whether the supply of NPPs is sufficient to meet the ensuing primary care needs. The short answer is no, but the current supply will certainly supplement the availability of primary care providers. As of 2010, the rate of new NPs is increasing at 9.44% per capita compared to 1.7% for physicians.[15] Approximately 12,600 NPs[16] and PAs[17] graduated in 2008, up from 11,200 in 2006.[18]

SCOPE OF PRACTICE AND PHYSICIAN ACCEPTANCE

Let's assume that physicians' previous opposition to expanded scope of practice laws was based on legitimate patient safety/quality of care concerns. In view of the evidence presented above, are those objections still valid? Is continued opposition to expanded NPPs' scope of practice laws still desirable given the physician shortage? We think the answer is no. Instead, physicians and medical societies should work with state legislators and groups such as the National Conference of State Legislatures (NCSL) to rationalize state laws and reduce the variation in state scope of practice laws.

As of now, state scope of practice laws vary widely on the key dimensions of NPP autonomy, drug prescribing, and test ordering. (The laws pertain more to NPs, since PAs are always under the supervision of physicians). Depending upon state law, NP scope of practice and authority can fall into one of the following categories from greater to lesser autonomy: independent practice; physician collaboration; or direct physician supervision.[19] The ability to order diagnostic and laboratory tests, as well as prescriptive authority, is directly related to NP autonomy.[19] In most states, NPs are limited to only ordering tests that are outlined in either written protocols or collaborative agreements.[19] Likewise, NPs face a continuum of prescriptive authority, ranging from full autonomy to limitations on the quantity and type of medications prescribed.

The variation in scope of practice laws affects the number of practicing NPs located within a state at a given time.[19–22] NPs tend to migrate to states that offer favorable practice acts and less restrictive rules that support autonomy, thus increasing access to care.[19,22] Unfortunately, the inverse is also true. States with restrictive practice laws and unfavorable regulatory settings attract fewer NPs, leaving these populations underserved and without adequate care.[19,23]

The keys for successful expansion of NPPs' scope of practice are legal accountability and physician acceptance. NPPs are responsible for the quality of care provided, although they are not legally accountable for their patients in the same way as physicians.[24] As they become increasingly responsible for autonomous primary care practice, their legal accountability is certain to expand.

Physician acceptance of NPPs as primary care providers lacks uniformity. Some providers believe that expanding the non-physician scope of practice will lead to impaired quality care, while further fragmenting the healthcare system.[25,26] Conversely, a majority of practitioners see the value in using NPPs to meet the increasing demand for primary care services.[26] Overcoming physician reluctance is vital for expanding NPPs' scope of practice and increasing autonomy.[24]

DESIGNING NEW PRIMARY CARE ROLES

Thus, what is to be done to address the primary care shortage? Since it seems inevitable that autonomous NPPs will be an essential part of the policy response, physicians can either lead the transition or run the risk of being marginalized in legislative debates. To avoid the latter prospect, physicians can take two major steps toward innovations in primary care practice: 1) abandon their opposition to NPPs and begin the process of defining separate primary care roles and functions for each profession; and 2) integrate population health considerations in primary care practice [27]

First, physicians should recognize the need to change outmoded scope of practice laws. To meet the market demand, NPPs' scope of practice must be changed to allow practice autonomy, prescriptive authority, and test ordering authority. This is likely to improve access in areas where primary care physicians are limited, specifically in rural areas and for underserved populations where they are already considered usual sources of care.[28] One way Massachusetts sought to fill the gaps in the primary care workforce was through the extended use of NPPs.[26]

Second, physicians should take the lead in restructuring and redefining the nature of primary care practice. One approach is to encourage the establishment of NPP-run community health centers, with referrals to physicians for more complex patients or where the diagnosis is uncertain. This would create a bi-level primary care structure, with NPPs largely responsible for routine primary care and physicians responsible for more complex patients and broader population health measures. Within this structure, both NPPs and physicians will treat the presenting symptoms that best match their education, training and skills. Reimbursement would be ordered accordingly, requiring negotiations with health insurers.

We are not suggesting a displacement of primary care physicians. Instead, our goal is to create a robust primary care practice with general internists at the forefront of restructuring and enhancing services and delivery. Based on their training and experience, there is every reason to expect that general internists are the most qualified physicians to retain responsibility for developing primary care practice guidelines and to audit NPPs' quality of care (similar to a peer review organization). To be successful, NPPs and physicians would need to collaborate on the best practices for implementation, operation, communication, and referral services.

Third, the ACA's focus on wellness and prevention opens opportunities for physicians to integrate population health into primary care practice. Through every day encounters with patients, physicians see the impact of illness and injury on individuals, as well as the effects of population health factors on individual patients. Physicians seeking to improve their patients' health must be concerned with both treating disease and preventing illness through education and supportive programs and policies. As a result, a core purpose of primary care should be improving population health. For example, Accountable Care Organizations could establish disease registries to manage patient populations.

We recognize that successful change depends on more than physicians' willingness to adapt to the new environment. To some extent it will depend on patients' inclination to accept NPPs as primary care providers, and a changing dynamic in the physician-patient relationship. The available evidence suggests that this will not be a barrier to new arrangements. It also depends on health insurers' readiness to examine new reimbursement models.

CONCLUSION

The expansion of health insurance coverage and the growth of the nation's population will drive the demand for primary care to levels exceeding current capacity. Whether or not one agrees with the ACA, millions of people who have not had access to primary care will now be seeking it. As a result, there are likely to be disruptive changes in primary care delivery. The only question is who will shape the new order. In our view, it is essential that physicians take the lead in re-imaging primary care delivery. As Thomas Paine put it, "Lead, follow, or get out of the way."

Conflict of Interest: *None disclosed.*

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