NATIONAL PHYSICIANS ALLIANCE

Policy Statement

Support of Comprehensive Health Workforce Reform to Improve Access, Quality, and Cost-Effectiveness of Healthcare

July 2013

The United States currently experiences a shortage and maldistribution of hundreds of thousands of health workers across all of the close to 100 recognized health professions in the U.S. This shortage and maldistribution is both in the geographical location of workers as well as in their skill mix (the skills they possess and the ratio of the numbers of one professional compared to another.) While there is ongoing discussion and study about the status of physician supply in the U.S., there is general consensus that there is a geographical maldistribution of physicians as well as shortages of primary care physicians, psychiatrists, and general surgeons. In the nursing profession, there are currently over 100,000 unfilled nursing positions in the U.S. and the American Nursing Association estimates that by 2020 the US will experience a shortage of close to 1 million nurses.

Over 65 million Americans live in Health Professional Shortage Areas as defined by the Health Resources and Services Administration. In an effort to fill some of the existing open positions in the US, the US imports tens of thousands of physicians, nurses, pharmacists and other health workers every year, mainly from some of the sickest and poorest countries in the world. Not only does this practice damage the health systems of poor countries, but it locks hundreds of thousands of Americans out of some of the most personally rewarding careers in our society.

These shortages and maldistributions limit access to care, negatively affect health, and drive up the cost of healthcare and the economic cost of illness. With the increasing demand for health services due to the aging of America and the 30 million people who are predicted to be newly insured through the Affordable Care Act, immediate action is needed to address true shortages where they exist, and create a more cost-effective health care workforce. Fortunately, new models of health professional education, community health programs, and patient-centered healthcare teams are examples of the types of initiatives that must be scaled up quickly to meet the pressing needs of our nation.

The NPA offers the following principles in support of comprehensive health workforce reform:

1. Health workforce reform should reflect the **team approach** in which healthcare is delivered and should address all the members of the healthcare team. Reform cannot focus just on one or two health professions.

2. Health workforce reform should be **comprehensive, evidence-based,** and focused upon a workforce composition that not only supplies workers, but **improves the nation's health**. In being comprehensive, it should address:
    a. Improving health workforce data, analysis and planning;
    b. Health workforce education and continuing professional development, especially in regard to cost and appropriateness of education (the match between health worker skills and population needs);
    c. Improving health worker distribution (both in regards to specialty and geography) and retention in underserved communities;
    d. Improving health worker performance, including quality of care and cost-effectiveness of care.

3. **Allied health professions** such as nurse practitioners, physician assistants, midwives, optometrists, dental therapists, EMTs, case managers, community health workers, and social workers should be introduced and expanded *where such health professionals would be cost-effective*.

4. Since the majority of healthcare costs result directly from activities of individual providers and provider teams, provider payment reform should **incentivize providers to use cost-effective forms of care** demonstrated to result in better health. Facility payment should incentivize the use of healthcare teams which have been demonstrated to be the most-cost effective way to deliver high quality care.

5. Provider and facility payment reform should **incentivize provision of care to underserved populations**.

6. Since the education of most health professionals is highly subsidized by state or federal funding, this funding should **incentivize innovation in the cost-effective training of sufficient numbers of appropriately skilled health workers**. Such innovations might include eLearning, interprofessional education, community-based education, and the rationalization of curriculum to remove unnecessary requirements which do not improve clinical care. Health professional schools and their accrediting agencies should engage in a dialogue with under-served communities and the employers of their graduates to ensure that they have the skills required by employers and community needs. Public funding of health professional education should be aligned with public health goals.

7. Until the entire cost health professional education (both tuition and real cost) is made more affordable, **additional innovative sources of funding for education need to be found**. This can include tapping into Job Corp funds in fields with high unemployment rates and low rates of job growth; partnership with underserved communities; or partnership with large employers of health workers who currently expend large sums of money in recruiting health workers in the severely constrained labor market.

8. Educational pipeline programs such as outreach programs, summer programs, and health services high schools should be developed to **recruit and graduate more health professional students at all levels from underserved communities**.

9. Creative incentives and support programs are needed to incentivize hospitals and clinics to increase clinical practica for health professional students.

10. The primary focus of the regulation of health professions and accreditation of health professional schools should be meeting state and national health goals. Any new additional requirement for practitioner licensing or school accreditation must be documented to be a cost-effective and improve access to care.

11. Since health workers are licensed and regulated at the state level and health professional schools receive significant state subsidies and other support, **there is significant opportunity for innovation and action in health workforce reform at the state level**.

References:

Andreatta PB. "A typology for health care teams." Health Care Manage Rev. 2010 Oct-Dec;35(4):345-54. doi: 10.1097/HMR.0b013e3181e9fceb.

CDC, "CDC Health Disparities and Inequalities Report--United States, 2011" MMWR, Supplement, Vol 60, January 14, 2012.

HRSA, "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations" accessed November 20, 2012, http://bhpr.hrsa.gov/shortage/

Institute of Medicine, "To Err is Human: Building a Safer Health System" Institute of Medicine, Washington, DC: 1999

World Health Organization, "Working Together for Health: 2006 World Health Report," World Health Organization, Geneva: 2006

World Health Organization, "Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations," World Health Organization, Geneva: 2010

United across medical specialties, the National Physicians Alliance was founded in 2005 to restore physicians' primary emphasis on the core values of the profession: service, integrity, and advocacy. The NPA works to improve health and well-being, and to ensure equitable, affordable, high quality health care for all people. The NPA strictly refuses financial entanglements with the pharmaceutical and biomedical industries.