Executive Summary

Background

The physician assistant profession is relatively new in relation to other health professions. It emerged in the 1960s in response to a dramatic undersupply of physicians at a time when the nation also began experiencing a rise in health care costs. During this period, returning medical corpsmen from Vietnam who were well trained and highly experienced found no place in the health care system to use their unique set of competencies. The combination of these needs and circumstances ultimately led to the formation of the physician assistant profession.

Physician assistants (PAs) practice medicine under physician supervision in a variety roles and settings. Some physician assistants practice as overflow providers for same day appointments, some staff urgent care departments or clinics, and others provide primary care in conjunction with a supervising physician. Many PAs practice with a significant amount of delegated autonomy, managing panels of patients as designated primary care providers or leading primary care teams that consist of non-physician providers as well as a supervising physician. In some rural areas, PAs function as their community's only health care provider. This variety of roles varies across markets, regions and care delivery organizations.

Physician assistant education, frequently termed a "condensed version of medical school", is generally 24 months in length. Programs exist in four different academic pathways: certificate programs, associate degree programs, bachelor's degree programs and master's degree programs. The PA portion of the training is the same regardless of degree level. The first year traditionally emphasizes didactic medical and biological sciences and the second year is devoted primarily to clinical rotations. Overall, PA education has been considered innovative in its emphasis on primary care.

Currently, 31,301 physician assistants now practice in the U.S.[1] While the profession was predominately male in its inception, the profession is now divided almost evenly between men and women and the 1996-1997 entering class is 61% female.[2] Legally, PAs practice within their own state legislated practice acts and under the delegatory power of their supervising physician. PAs are legally recognized to practice in 49 states, the District of Columbia and in Guam. Additionally, physicians may delegate prescribing to PAs in 41 states and the District of Columbia. In 32 of those states, PAs may additionally prescribe controlled substances.

Role of PAs in Managed Care

As managed care creates new mechanisms for the delivery of health services, it will inevitably put pressure on the role and function of health professionals. Physician assistants will not be exempt from these changes. In fact, many of these shifts may strain the relationship between the PA and physician and other non-physician providers. There will be corresponding demands for changes in the scope of training, time in training, and pathways to professional practice.

Physician assistants have long provided high quality, cost-effective care with demonstrated outcomes in quality and patient satisfaction. The flexibility in which the profession was created has allowed for new PA roles to evolve. This flexibility has led to more innovation within the health care system and offers more promise for the future. As local markets vary, each engaged in a different stage of managed care penetration, they will value a variety of innovations. Some markets will value physician assistants that function as integrated members of primary care teams, while other markets will seek the PA who functions in an adjunctive manner. In other words, managed care will likely value physician assistants only as PAs are able to fill niches demanded by a variety of markets.

The care delivery system has and will continue to value physician assistants for their cost effectiveness in relation to physicians. But as the salary differential between primary care physicians and PAs narrows due to physician oversupply, some care delivery systems may see less value in hiring a PA over a physician. Again, this will vary from market to market and by region.

Recently, the number of training programs for PAs has increased. Within the past year, Committee on Accreditation of Allied Health Educational Programs (CAAHEP), the accrediting body for PA programs, awarded accreditation to 18 new programs, bringing the total to 104. At current rates of growth, an Association of Physician Assistant Programs research panel estimated that the number of PAs practicing clinically will double by the year 2006.[3]

In light of the overall expansion of primary care providers and the continuing oversupply of physicians, predicted future demand and appropriate production levels of PAs become two important issues. However, effectively judging demand and appropriate production levels are complicated.

Citing rising salaries and the high percentage of PAs in clinical practice as evidence of current demand, some argue that demand for PAs will continue to remain strong in the near future. Salaries have increased steadily since 1991, suggesting that the equilibrium between supply and demand has not yet been reached. Changes in Medicare reimbursement policy and the potential to substitute PAs for hospital based residents are two factors that may increase future utilization. Perhaps most compelling is the argument that PAs are cost-effective providers, a fact not lost on cost-conscious managed care organizations.[4]

However, evaluating the demand for PAs must be done in context of the supply of other primary care providers and the evolution of the profession. Historically, the physician assistant profession was created during an era of physician undersupply. Trained in a short amount of time as flexible generalists, PAs practiced primary care, often in rural areas. Even as recently as 5 years ago, physicians frequently viewed both the type and location of PA practice as undesirable.

But recent competition from other providers for primary care jobs has increased in many areas. From 1994 to 1998, more than 50% of medical students chose to pursue generalist residencies and this spring, 56% of graduating US medical school seniors selected a residency in internal medicine, family practice or general pediatrics.[5] There has also been a proliferation of advanced practice nurses that are competing in the marketplace for primary care jobs.[6] Data on nurse practitioners suggests that there has been growth in the number of programs opened, with the number of NP graduates rising from 1,993 in 1993 to 4,003 in 1995.[7,8]

As a result, the well-documented oversupply of physicians and recent increases in nurse practitioner production may create greater competition for fewer jobs with lower rates of compensation. With the oversupply of primary care providers and resultant underemployment of physicians, PAs and NPs may witness a backlash from physicians wishing to reassert their roles and authority.

Efforts to effectively judge the optimal number of PAs for our dynamic health care environment are problematic. Ultimately, the market will decide, based on a variety of factors. The willingness of managed care organizations to utilize PAs, the available supply of NPs, PAs and physicians, the aging of the U.S. population, the possibility of substituting PAs and NPs for displaced residency positions, wage rates, cultural expectations of communities, and the aggressiveness of managed care are all factors that will influence demand.

PA Training

Two related and important issues surrounding training exist for the profession as well. The first centers around the ability to secure clinical training sites. As training sites face mounting financial pressures, many conclude that they cannot "afford" to conduct teaching programs in their clinics. Compounding this situation, non-hospital ambulatory sites may now be reimbursed for training physicians, a subsidy that previously did not exist. As training sites face increasing cost pressures, professions lacking funding support for clinical training will be at a disadvantage as they compete against physicians for these sites.

Second, PA training programs should also enlarge their emphasis on the delivery of care in managed settings and provide PAs with the skills for effectively managing care in organized settings. Although the foundation of PA education and training prepares physician assistants to be generalists, such training will not be sufficient to adequately prepare future PAs to practice in intensively managed care settings. Both the education and accreditation process should stress this reality in the design and structure of educational programs. Schools must continue to emphasize the centrality of primary care, teach the skills associated with providing population based care, emphasize the need for accountability at all levels, teach students how to gather and use information to assure value, emphasize the interdependence among health and human service professions and teach students about the linkages between health care delivery and finance.

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[1] American Academy of Physician Assistants, Division of Research and Data Services, 1998.

[2] Thirteenth Annual Report on Physician Assistant Educational Programs in the United States, 1996-1997. Alexandria, VA: Association of Physician Assistant Programs, 1997.

[3] Association of Physician Assistant Programs. Blue Ribbon Panel Report. Perspective on Physician Assistant Education, Winter, 1998: 27.

[4] Hooker R. The Undersupply of Physician Assistants. JAAPA 1997; 10:81-102.

[5] Association of American Medical Colleges. Majority of U.S. Medical School Graduates Continue to Enter First Year Primary Care Residencies. AAMC News, March 22, 1998.

[6] National League for Nursing. Nursing Datasource, 1996: Graduate Education in Nursing, Advanced Practice Nursing. New York, NY: NLN Center for Research, 1996.

[7] It should be noted that the NP programs enroll the majority of students on a part time basis. Although there were only 4,003 graduates in 1995, there were 18,030 enrollees in master's level NP programs.

[8] These figures only include master's level NP programs and do not include certificate programs that train NPs.

The Task Force and the Commission make the following recommendations:

THE PHYSICIAN ASSISTANT - PHYSICIAN RELATIONSHIP

R1: In light of these challenges, the physician-PA relationship, defined by delegation and supervision, should be reaffirmed as it was created and has existed. It should not be re-defined with the PA having more independent authority from the physician. Physicians and physician groups should be projecting the PA into the new types of relationships that are emerging in systems of managed care. This will create new types of relationships between PAs and physicians, all of which should maintain the traditional values and intent of the PA-physician relationship.

R2: As physician assistants move into organized practice groups and begin to work with multiple supervisors, they should be incorporated into the medical staff.

PHYSICIAN TRAINING

R3: Where possible, all graduate medical education residency programs should insure that a component of training includes an extensive practice opportunity with a physician assistant or nurse practitioner. This training should be carried out in a setting that encourages team practice.

PHYSICIAN ASSISTANT - NURSE PRACTITIONER RELATIONSHIP

R4: Closer collaboration at the national policy level should exist to attain mutual goals such as defining the use of PAs and NPs in managed care, defining the health services research agenda to demonstrate the cost, quality and patient satisfaction associated with the use of PAs and NPs in these settings, and dealing with the issues of finding training and preceptor sites within managed care. The best way to facilitate the development of such an agenda would be the creation of a national summit with representatives from managed care organizations, the educational groups associated with PAs and NPs and the respective practitioner communities. The summit should develop a specific research, education, and practice regulation and public policy agenda as an outcome.

PHYSICIAN ASSISTANT EDUCATION

R5: Concepts including population-based care, accountability, use and importance of information and demonstrable outcomes, interdependence among the health and human services professions, linkages between health care delivery and finance, and general emphasis on primary care are all topics that should be incorporated, but not lengthen, PA education and training. This will mean that these elements will have to be added to existing course and clinical work in programs that do not currently incorporate them. These changes will be most efficient if there is national leadership in the development of curricular material that can be adapted to the needs of specific programs.

R6: Accreditation standards should be restructured to encourage training programs to incorporate these principles within their curriculum.

R7: The level of federal subsidy available to PA educational programs should not be enlarged as a way to increase class size or begin new programs. No changes in Title VII policies should be made to fund a broad subsidy.

R8: Appropriate federal and state subsidization should be provided to PA educational programs to attract, recruit and retain individuals from underserved rural and urban areas or to achieve other policy goals that address broader health care concerns and issues.

R9: Analysis of long and short-term market conditions and maintenance of high quality standards should guide any further expansion of educational programs. In addition, there is evidence that physicians and other health care professionals are and will continue to be in oversupply. Emerging health systems will utilize a mix of health care providers to meet the demands of quality, cost containment and access as these issues are interpreted by health systems and vary across regions. Given the general oversupply of health care workers and the changeable nature of healthcare workforce staffing, it would be appropriate for all health professions to remain vigilant about the size of the workforce needed. Because of the relative shortness in training time for PAs in comparison to physicians, the profession may be more readily adjustable to changing needs.

R10: Regardless of payer source (HCFA or an all-payer pool), federal funding for graduate medical education should be made available to support the training of physician assistants and advanced practice nurses in clinical settings. These funds should be paid directly to the clinical service site providing training and not to the educational programs that are responsible for organizing and conducting education.

REGULATION OF PHYSICIAN ASSISTANTS

R11: State practice acts should not have arbitrary practice barriers. Physician assistants should be able to practice to the full extent of their education, training and experience as delegated to do so by a supervising physician.

R12: State practice acts and insurance payment policies should not be a barrier to the full practice of PAs under existing state laws.