Introduction

Since the 1960s, physician assistants (PAs) have been influencing the way health care is delivered in this country. Although the profession is only 30 years old—relatively young in comparison to some other health professions—PAs have become a major component of the U.S. health delivery system.

The award-winning television show "ER" has probably done much to raise public awareness about the role of PAs in health care delivery. Today PAs can be found practicing in virtually every kind of health setting, helping to assure access, improve quality, and restrain the cost of services.

But like all health providers, PAs are facing many challenges. They are practicing in a health care environment that is dramatically different than when the field profession began 3 decades ago.

In the past 10 years alone, the $1.2 trillion American health care system has
undergone a revolutionary change. Exploding health care costs and a desire for efficiency have led to major changes in the way health care is organized, delivered, and financed. The changes have affected consumers, purchasers, providers, and insurers.

The health care delivery system was once dominated by an unrestricted fee-for-service model. Today, 4 in 5 working Americans are enrolled in tightly controlled managed care plans that are oriented toward health prevention and wellness instead of illness. These plans, including HMOs and PPOs, attempt to limit "unnecessary care" and offer restricted networks of providers who must deliver a defined set of health care benefits for a fixed fee.

Patients, who used to be able to freely choose their doctor or hospital, today sometimes have to seek permission from "gatekeeper" primary care doctors who are providers for routine services. Physicians, once independent agents with primary clinical authority who could bill and be paid for their services without much challenge, now must wait for a health care plan to authorize treatment as well as reimbursement.

Meanwhile, health care has become a corporate endeavor, with investor concerns taking precedence over public-related concerns. Although local nonprofits still dominate the U.S. hospital sector, more than 800 public and nonprofit hospitals became for-profit facilities over the past decade. The non-profit, staff-model HMO, which symbolized the managed care industry during its early years, has been subsumed by a larger, aggressive for-profit sector. Between 1988 and 1994, membership in for-profit HMOs grew by 92% whereas non-profit membership grew only 25%. In 1997, nearly 60% of HMO members were enrolled in for-profit plans.

The new health care system is dramatically redefining the roles, responsibilities, distribution, and use of health professionals. The force of a competitive market—where aggressive purchasers are setting performance expectations, demanding better reporting of outcomes, and pressing for cost-efficient delivery strategies—is blurring the lines of responsibility that have traditionally divided the health professions, shaking up the once secure dominions of doctors, nurses, and others. Doctors are being told to be team players, nurses are seeking autonomy, and a widening field of allied and nontraditional providers are pressing to expand their responsibilities.

The move to integrate health care delivery is provoking an examination of the roles and competencies of all health care workers. As a result, many health professionals will likely be displaced while others could face new opportunities.

### The Implications for PAs

In many ways, managed care has been very good for PAs. However, a health care system focused on costs and efficiency also puts more pressure on them to continue to define their roles, functions, and values.

On the positive side, today's health care system is oriented toward many of the values that the PA profession has long embraced: primary care, outcomes measurement, patient education, and multidisciplinary teamwork. The new health system is oriented toward health instead of illness, population-based medicine, information, consumer knowledge and satisfaction, outcomes, interdependence, and accountability—all things that mesh with the philosophy advocated by the PA profession. With 53% of the nation's practicing PAs specializing in primary care, they have a lot to contribute to the current health delivery system.

The pressures of a market-driven health system have strained the relationships among all health care professionals. Physicians and others complain about feeling besieged by a perceived loss of independence and clinical control spurred by a cost-driven health system. Physicians also are feeling threatened and are worried about an encroachment into their practice territory by other practitioners. Some physicians even wonder whether PAs are practice enhancers or competitors.

The fear of encroachment by other health professions may not be unfounded. In an interview in the New York Times, Dr. Alan Hinkle, corporate medical director of New Hampshire Blue Cross, noted that today's health system needs "many different types of providers...it's no longer just a physician driven system."

Many argue that the health system has not completely realized the full potential of PAs, noting that the number of providers is insufficient to meet the growing need for primary, preventive, and emergency care services, and the needs of underserved populations. As the PA profession charts its future, it will have to continue to balance the concerns of physician partners with the need to emphasize the cost savings and value that the profession offers to the new health care model.

### History

The PA profession evolved in the 1960s when the U.S. was facing a serious shortage and maldistribution of physicians to address the nation's need for primary care services. Medical corpsmen returning from Vietnam wanted civilian jobs to apply the skills they honed on the battlefield. The PA profession was seen as a way to improve the supply and distribution of primary care services and extend the practice of a physician. After the first educational program opened—at Duke University—PAs began to "close the service demand gap by making services more available, accessible, and affordable, particularly in underserved areas."

The first major expansion of PA programs began in 1971, thanks to the advent of federal funding. From 1970 to 1980, the number of PA programs grew more than four-fold from 12 to 51. This rapid growth of programs steadied during the 1980s and by 1992 a total of 55 programs were established.

Since then, the PA profession has flourished. Through 1998, more than 40,000 individuals became eligible to practice as PAs, up from 24,000 in 1990; about 83% of them are in clinical practice. The number of accredited schools graduating PAs has grown significantly in recent years, climbing 100% between 1992 and 1997 to 110 programs in 1998. Although PAs comprise an exceedingly small percentage of the nation’s clinical workforce, the PA profession is a burgeoning one that is expected to more than double in size by 2010 to more than 87,000 eligible to practice.

Challenges

For the nation’s nearly 750,000 clinically practicing physicians, the prospect of substantial growth in the supply of PAs is potentially troubling. And that concern is one the PA profession is seeking to address.

Managed care, which calls for fewer staff requirements for physicians and other clinicians than the fee-for-service sector did, is clearly dampening demand for physician services, particularly specialty care. But that demand is not decreasing as sharply as some had projected. Key reasons for this are attributed to the rapid growth of point-of-service HMO plans that let enrollees go out of network for specialty care, and increasing attempts by state and federal lawmakers to assure managed care-wary constituents the right to see any provider of their choice.

Nevertheless, the growth in the supply of nonphysician clinicians, particularly PAs and nurse practitioners (NPs), has been significant over the years. That growth among a core of primary care specialists, according to one analysis, is threatening the professional sovereignty of physicians. According to a recent editorial by Kevin Grumbach, MD, and Janet Coffman, MPP, nonphysician clinicians "do not seem content to provide care only for populations abandoned by physicians." The challenge for the health professions in the future, they argue, will be "to develop models that promote" a complementary relationship "while mitigating the harsh competition that may be the unhappy by-product of uncontrolled growth in the health professions." While PAs remain absolutely committed to their team approach to care with their supervising physicians, the profession often is "lumped" with other professions pursuing a more competitive approach to physicians.

An Increasingly Competitive Market

One of the biggest issues has been and will continue to be centered on the number of PA educational programs. Within the next decade, the rate of growth in the number of new nonphysician clinicians, including PAs, is set to exceed the growth among physicians.

According to an article that appeared in a recent issue of the Journal of the American Medical Association (JAMA), the number of traditional and alternative nonphysician clinicians per capita is set to grow by about 60% between 1995 and 2005. In contrast, the supply of physicians per capita is projected to climb more than 10% over that period.

With a job growth projection of nearly 47% over the next decade, the employment outlook for PAs is favorable. Most observers concede, however, that increased competition between physicians and nonphysician clinicians generally is virtually inevitable. This is an obvious outcome in a fiscally constrained health system that has a perceived glut of physicians and scarcity of primary care providers. To paraphrase a 1981 Eugene Stead proclamation: Physicians are human. If you start hitting physicians in their pocketbooks with regard to PA or NP utilization, they will react the way you would expect any other health profession to react. In other words, preserving turf is a real phenomenon that could strain relations between historic partners.

PAs have been cited by Cooper, et al. as one of the few nonphysician professions that are paying attention to the effect of an impending surplus of nonphysician clinicians and physicians. Nevertheless, the fears about turf battles are being raised. Grumbach and Coffman note that NPs and PAs can perform many of the clinical tasks of physicians and provide "equivalent quality of care within their scope of practice." Cooper notes that as the breadth of clinical responsibility expands for these professionals, nonphysician clinicians are gaining easier access to private and governmental insurers, and are being integrated more readily into both managed care organizations and physician group practices. The key for PAs is that their practice is always conducted within the context and framework of physician supervision.

In fact, PAs are facing intense competition for jobs. Although the PA job market isn’t static, there are many more professions vying to provide primary care services.

Newly graduated physicians are one group that could affect the numbers of jobs available to PAs. Medical residents have complained of a restrictive job market in some specialties and regions of the country. According to the Association of American Medical Colleges (AAMC), more than one-half of graduating U.S. medical school seniors planned to pursue training in a generalist specialty such as internal medicine, pediatrics, or family practice for at least one year of their residency—the third consecutive year these data were reported.

The lower staff-to-patient ratio requirements among managed care plans, a growing focus on assuring patient satisfaction, and a desire to get the best value for the dollar could result in primary care physicians competing against PAs and NPs for a limited number of slots.

NPs, who also are trained chiefly in primary care areas, are competing with PAs for jobs. The number of NPs trained in the U.S. has grown significantly in recent years. Between 1992 and 1997, the number of institutions offering NP programs has grown from fewer than 100 to 250.
In 1992, there were fewer than 4,000 NP students; by 1997, enrollment had surged to more than 20,000. The number of NPs graduating annually has grown more than four-fold from 1,500 in 1992 to 6,350 in 1997.

There is growing concern among PAs that the job market for their services is tightening, especially in regions with a large supply of PAs such as the Northeast and southern California. Other areas of the country, such as the Southwest, still have a need and demand for PAs.

The Demand for Education

One of the toughest quandaries facing the field is whether it can continue to expand the numbers of educational programs and graduates in the face of an oversupply of physicians. In the past 6 years, the number of accredited PA programs has doubled from 55 to 110. Within the past year alone, the PA educational program accrediting body, the Commission on Accreditation of Allied Health Education Programs, awarded accreditation to 9 new PA programs.

Although the pool of graduates from medical schools has been stable for years, the number of graduates from PA schools has nearly doubled since 1989, from 2,500 to nearly 4,000, reports the AAPA.

Over the past 2 years, the number of applicants to medical schools has been dropping, particularly among minorities, according to the most recent data from the Association of American Medical Colleges. Between 1996 and 1997, there was an 8% drop in medical school applicants; between 1997 and 1998, there was another "measurable" drop of 5%, AAMC reported in 1998.

But the trend in PA education appears to be different. The tremendous demand for PA education has fueled a tremendous growth in educational programs.

APAP estimates that between 14,000 and 17,000 people sought PA education in 1997, yet there were only 2,500 available slots. The growing interest in the field stems from a variety of factors. The average age of a PA student is 30 years. Those who want to provide medical care to patients, but do not want to attend medical school for the 7 or more years required, are attracted to the PA profession. In addition, the cost of PA education is considerably less than what it costs to become a physician ($25,000 compared to $200,000). Finally, PAs work on average fewer hours than physicians and have more control over their schedules and lifestyles.

The Physician/PA Relationship

Unlike other markets in health care, the market for PA services is a "derived" one. PAs are not independent providers. The demand for PAs is strongly linked to the demand physicians make for them.

The interdependent relationship that PAs have with physicians is one the profession is committed to maintaining. Unlike NPs, many of whom want more independent practice authority, PAs reject the idea of independent practice and independent reimbursement. PAs now have practice rights in all states except Mississippi, where registered nurses have successfully fended it off. The AAPA reports that PAs have prescriptive authority in 46 states as of April 1999.

In their work with physicians, PAs routinely perform physical exams and take patient histories, order and interpret laboratory tests, diagnose and treat illness, suture lacerations and assist in surgery, write prescriptions in nearly every state, and provide health education and patient counseling—all as delegated functions of the supervising physicians. PAs work in complementary and synergistic ways with physicians. They foster an integrated rather than a fragmented care system, assure continuity of care, and embrace the tenet that two heads are better than one.

Proving Value

A large part of the value that PAs bring to the health system and patient care derives from their close relationships with supervising physicians. A recent survey by the AAPA found that PAs rated the level of respect they receive from physician co-workers as "very strong." Although they are in a team relationship with physicians and have the word "assistant" in their title, that same survey found that PAs feel they garner high respect from patients as well.

For physicians, interest in PAs comes down to what the perceived value of that professional is and what the PA will add to the practice: a. Are patients happier because they are getting their questions answered? b. Do PAs allow the physician to focus on conditions and problems where their more extensive training and knowledge can be used? c. Do PAs supplement their supervising physicians' services with additional skills and knowledge? and d. Can PAs increase reimbursement to the practice?

Many studies have shown PAs add a lot of value to a practice, including quicker appointments, better attention to patients, and follow-up care.

One quarter of patients surveyed said that their doctor appointments were sometimes handled by a nonphysician, and nearly 9 in 10 of those respondents were very or somewhat satisfied with the care they received. With salaries at 40 to 50% of the level of the typical primary care doctor, physician extenders such as PAs were described as the "economical solution to managed care's challenge," freeing doctors to treat more patients for "less money" and to handle more complicated and "remunerative" tasks.

A 1997 study by the New York-based Commonwealth Fund found that 4 in 10 physicians spend less time with patients today than they did in 1994. For many doctors, reliance on PAs and other physician extenders results in higher productivity, greater patient satisfaction, and higher income. Physicians describe these practitioners as valuable...
additions to health care teams because they follow up with patients, spend time to educate them about disease, and encourage them to change unhealthy behaviors that lead to higher health care outlays.

According to the latest data available, nearly 60% of group practices employ nonphysician practitioners (NPPs), according to the American Medical Association. A 1995 AMA survey found that physicians working with NPPs supply more hours in office visits and patient care than physicians without these practitioners. They also reduced the number of weeks physicians work per year by about a week and enabled physicians to expand the scale of their practice. These productivity changes generated an 18% increase in physician net income.

The value that PAs bring to practice is evident by the sites in which these professionals work. The arenas where the health care market and enrollment are growing most rapidly—group practice settings are where PAs can be found.

The most recent data from the AAPA show that more than a third (38%) of PAs are employed by single or multi-specialty physician group practices. Slightly more than a quarter (27%) are employed by hospitals, although the vast majority of these PAs work in outpatient settings.

Another set of key elements that the profession offers this new changing health care market is experience and diversity. Unlike medicine or nursing, most PAs enter the profession with other kinds of clinical experience. Most applicants have an average of 4.5 years of experience, usually in the health field. Some 64% of entering students already have a baccalaureate degree, according to AAPA data.

It also is one of the most gender-balanced professions. Although it began as a male-dominated field, females now comprise 53% of practicing PAs. The female/male split in schools is about 60/40; thus, the future PA pool will be comparable to the population at large.

The PA profession also has a higher percentage of non-Asian minority students than other primary health care professions. There are about 9% of PAs who are nonwhite in practice today. But the population in training is about 20% nonwhite. This suggests that a more culturally sensitive PA profession will be delivering care to an increasingly diverse population of consumers.

Historically, the role of the PA has been to fill niche markets such as rural health care, hospital-based care, and urban health care—gaps left by other provider communities. That is a very important role as the profession considers its future. The PA profession historically has provided medical care in areas of the country where fewer physicians have chosen to locate. Nearly one-third of PAs work in areas with fewer than 50,000 people. If the oversupply of physicians is really a distributional problem, PAs can continue to fill some of the areas where there is a short supply.

PAs also are poised to fill widening gaps in hospital care. The fiscal and time pressures of daily practice are leading a growing number of primary care physicians to relinquish their hospital-based business to a new specialty of "hospitalists." The growth of hospitalists translates into more slots for PAs in the acute-care setting where they already have experience.

A growing number of teaching hospitals—faced with the loss of traditional physician residencies as a result of a 1997 law capping Medicare graduate medical education payments—are increasingly turning to PAs to fill the slots once held by residents. PAs with 2 years of graduate training are one of a growing group of physician extenders delivering care to patients at a New York hospital. PAs will work hours comparable to residents and will receive specialized training in such things as emergency care and critical care. In 1998, at least seven new PA residencies were developed at teaching institutions in emergency medicine, general surgery, otolaryngology, neonatology, and psychiatry. The emerging role of the "hospitalist" may impact on this evolving role of PAs in hospital settings.

Assuring Professional Competency

Where the PA profession seems to be leading the health care field is in the area of professional competency. In a recent report, the Pew Health Professions Commission wrote that "ensuring the competence of health professionals throughout their careers is a persistent challenge to both public and private sector." The Commission embraced the idea of requiring periodic demonstrations of competence as a condition of licensure, which is something that physician assistants and emergency medical technicians do, while most of the health professions boards—including boards of medicine, nursing, and pharmacy—do not. The PA profession agrees that practitioners' competence tends to diminish after initial licensure, and continuing education credits do not necessarily guarantee competence. Thus, every 6 years PAs have to be recertified in primary care.

Historically, PAs have been highly valued because of the short period in which they are educated—2 years. Because they are trained with a core set of primary care skills, PAs are extremely flexible and are able to gain significant skills and knowledge from on-the-job experience over their career span. Although some say that a minimum degree requirement would elevate the profession's credibility, the profession to date has focused on competency as a better way to measure skills and allow for more diverse practitioners who can serve areas of special need. While suggestions have been made to extend the training time for PAs through residency-type programs, the low cost and short training time are what contribute to drawing quality professionals to the field. And the health system is looking for ways to be more effective and efficient. The PA profession is a mid-career option for many health professionals who bring not only prior clinical experience but also many years of life experience to their work as PAs.
**A Strategic Plan for the Physician Assistant Profession**

**Keys to Continued Success for PAs in the 21st Century**

With the above issues and challenges in mind, our group of health care experts met in Boston in the summer of 1998 and compiled a number of recommendations that will assure the continued success of the PA profession as it enters the 21st century. Amid advancing technology, greater use of telemedicine, more emphasis on integrated delivery systems, and a growing awareness of the power of the consumer, this group believes this set of principles will enable the profession to grow while ensuring that it keeps to its core mission.

**Core Concepts**

**The Primary Care Training Education Base**—The PA profession should remain rooted in its primary care foundation, with an emphasis on lifelong learning. Although PAs do work in specialty areas, the generalist basis of their education remains critically important to their future.

Lifelong learning is an important component of PA education. The health care system is rapidly changing; a commitment to continuous lifelong learning is a way for PAs to enhance the value they bring to physician practices as well as the health system at large.

**Multiple Roles and Flexibility**—Eschew a 1-model-fits-all approach for the profession. PAs should have multiple roles to maximize the interest and capability of each individual. The traditional flexibility that PAs have had to work in a variety of settings and situations has proved to be of real value to the profession and the health care system. This should be preserved.

**Competency**—Clinical competency should be favored over academic degrees. Although it flies in the face of what many in society believe about "competency," the competency-based approach of the PA profession is relevant to the market needs of today and the future. PA programs are producing excellent clinicians, regardless of degree level, and the profession should continue to emphasize clinical competencies. Lifelong learning with periodic competency checks maintained over a professional career is more important and follows the recommendations of the Pew Health Professions Commission. This would allow for a more diverse student population as well.

The PA profession should also continue to embrace the concept of a strong system of recertification of every six years.

**Limits of Knowledge**—Emphasis should continue to be placed on respecting the limits of clinical knowledge and knowing when to seek consultation. One of the great strengths of PAs is that they know, understand, and respect the limits of their knowledge. The interdependent relationship with a supervising physician assures that the appropriate strengths of PAs is that they know, understand, and respect the limits of their knowledge. The interdependent relationship with a supervising physician assures that the appropriate competencies. Lifelong learning with periodic competency checks maintained over a professional career is more important and follows the recommendations of the Pew Health Professions Commission. This would allow for a more diverse student population as well.

The PA profession should continue to embrace the concept of a strong system of recertification of every six years.

**One Set of Education Standards**—To assure consistency, the profession should be committed to requiring a minimum 2-year standard for the preparation of a PA. Some concern has been expressed about the potential erosion of this standard in the face of a growing number of international medical graduates (IMGs) wishing to practice as PAs because of new restrictions on Medicare graduate medical education funding. The profession believes that IMGs and any group wishing to practice as PAs must go through the same educational process. A key part of PA education is socialization into the dependent role; it is very difficult to take someone who has been trained to be independent and have him or her work as a PA. Thus, if someone wants to become a PA, he or she should go in the front door: attend PA school, become educated in 2 years, and take the same competency tests that other PAs have to.

The PA profession should oppose the idea of lengthening the time period for basic education. It runs counter to market needs today.

**The Physician/PA Relationship**—The interdependence between the PA and physician via a supervisory relationship should be kept intact. PAs practice medicine as a delegated function of the supervising physician. Independent practice and independent reimbursement run counter to the PA philosophy and should be rejected.

**Interdisciplinary Care**—PAs work with physician supervision, and the PA profession supports and strongly believes in a multidisciplinary team approach to delivery of services, to promote cost-effective, high quality care.

**Mission/Vision**

**Consumer Knowledge**—PAs serve an important role because they work with patients to explain chronic care for such things as diabetes. PAs have a very important role to play in enhancing consumer knowledge and helping consumers become more active and involved in their care. Consumer knowledge is becoming one of the more important areas of health care today. Empowering consumers is seen as a way to begin to control health costs and promote healthier behaviors.

**Patient Access**—PAs should continue to focus their skills on serving underserved populations. With more than 43 million uninsured Americans, PAs should promote access to care for all populations with an emphasis on underserved communities. The field also should promote care that is culturally sensitive to an increasingly diverse population of patients.

**International Influence**—PAs should extend their knowledge, skills, and experience to other parts of the world so the profession can have national and international exposure.

**Professional Recognition**

**Professional Title**—Preserve the PA title and build on it as a source of strength to help the public better understand how the physician and PA work as a team and what the produ-
uct of that team approach is. PAs in specialties should be recognized for their experience, additional training, and capability but not in such a way as to create additional credentials required for practice.

**Role/Utilization**

**Access**—Use PAs to widen access to care as well as reach out to new patients and help physicians sustain their practice. Ensure that PAs are creating an efficient service delivery system in which the physician’s knowledge and skills are being put to best use and the PA’s knowledge and skills are being put to best use.

**Value**—Ensure that PAs are not being used simply because they are a less expensive alternative. They shouldn’t be tapped simply because they return money to a practice; they should provide a value to the practice.

**Education**

**General Challenge**—Consider the implications of expanding the number of PAs, educational programs, and student slots.

**Complementary Education**—Approach medical school deans to educate them about the PA profession as a way of reducing barriers to linkage of education programs; talk about sharing teaching and faculty resources through technology such as teleconferencing. PA training programs should integrate more with communities to help enhance their image and value among the public at large. Tie PA education to physician education.

**Education Partnerships**—PAs should train with physicians and other health professionals. The training models should emphasize communication skills and the ability to transfer knowledge to patients. They also should continue to emphasize primary care as a core foundation of PA education.

**Diversity of Student Body**—There should be an emphasis on increasing the diversity of the student population to mirror the population in both demographics and experience. Efforts should be made to recruit a diverse workforce and retain them to graduate. Enrichment or remediation programs should be developed to assure a rich mix of students who may need extra assistance. Increase Title VII funding to enhance the student body and focus on minority recruitment and retention. (See Table 1)

**Faculty Support**—PA programs and the federal government should create faculty development programs to assure a supply of high quality culturally and professionally diverse faculty. Faculty need to be focused on recruitment, retention, and mentoring.

Encourage development of a separate faculty development grant program and a separate grant for interdisciplinary education in community-based clinics and underserved areas. (See Table 1)

**Table 1**

**Proposed Projects**

In response to the recommendations of this report, the Association of Physician Assistant Programs (APAP) has proposed several projects or activities that directly address issues related to diversity and strengthening the faculty base for the profession. These recommendations include:

- Provide financial assistance to establish a fee waiver program for financially disadvantaged applicants to PA programs who will apply through a centralized application service (CASPA).
- Support a survey of senior PA students that addresses areas of curriculum, competency, psychosocial skills, etc.
- Support the development of a Web-based distance education course in medical Spanish. (page 13, paragraphs 4, 6, and 8)
- Support an issue of *Perspective on Physician Assistant*, the only journal for physician assistant educators, dedicated to a topic relevant to the goals of Title VII, such as faculty development, minority issues in education, and evidence-based medicine.
- Support the ongoing needs for faculty development for PA educators:
  - A basic skills faculty development workshop
  - Faculty development workshop II (a continuation of basic skills)
  - Clinical coordinators workshop
  - Experienced program leaders
  - Train-the-Trainers workshop for different faculty roles
- Support the creation of a basic skills book for new PA educators and a Grant Writing Workshop
- Support a workshop or workbook that would introduce concepts of evidence-based medicine, representing a shift in practice that requires faculty to master new skills that educators may not have previously utilized in practice.

**Additional Education**—Explore opportunities for additional formal education, including use of re-entry programs, residency programs, specialty knowledge training, and practice-based learning programs.

**Clinical Sites**

**General Challenge**—Assure adequate supply of clinical training slots for PA students. Use telemedicine to support community-based clinical education to the extent that it is a valid need and feasible.

**Interdisciplinary Education**—Require sites to provide interdisciplinary training and encourage development of a separate federal grant for interdisciplinary education in community-based clinics and underserved areas.
Diverse Patient Population—Promote rotations in clinical and organizationally diverse settings to increase exposure of students to the many facets of health care delivery, particularly in underserved areas.

Get more PA students interested in National Health Service Corps sites, Indian Health Service sites, and other clinical work committed to helping to widen access to care for underserved and uninsured populations.

Supply & Demand

Role PAs Play—Continue to advocate increasing access to health care. To address the supply question, assure that PAs are competitive, quality professionals and that they add value not just quality. Better define how PAs are cost-effective and in what ways physicians, health plans, patients, and society benefit from this outcome.

Workforce Needs—Promote development of National Health Service Corps sites, where PAs could help fill underserved areas; promote research on the cost-effectiveness of the physician/PA team and provide data showing why PAs in the system are important, valued members. Ensure that PAs are represented on all national health workforce planning activities. Help to improve the understanding of how PAs augment or add to the practice of physicians, not just assist or substitute with supervision for the services of physicians.

Place reliance, where appropriate, on the market to resolve the workforce/supply issues. Work collegially with physicians, nurses, and those from other professions on this problem.

Balance—Pursue a socially responsible policy to monitor the supply of PAs to assure a better balance between the demand for health care and the supply of all professions.

New Markets—PAs need to explore new models of practice organizations and be prepared for roles to assist hospitalists and work in hospital settings in place of residents.

Regulations

Mississippi—Continue efforts to remove practice authority barriers in Mississippi, the only state that has not passed authorizing legislation for PAs.

Quality Assurance—The PA profession should work with other quality assurance systems to promote focus on quality and credentialing in integrated health care systems. The PA profession should work with other quality assurance systems, including the American Medical Association’s accreditation program (AMAP) program.

Certification and Credentialing—Assure that PAs have tools for recertification and provide alternative pathways for certification. The profession should develop its own standards for re-credentialing and credentialing before others do it for them.

Reimbursement

HCFA—Continue to work with the Health Care Financing Administration to give HCFA staff a better understanding of the PA concept; Medicare requires supervision for things that don’t necessarily require a physician’s eye, such as diagnostic tests.

Coverage—PAs should develop strategies to ensure coverage by all insurers of a full spectrum of physician services provided by PAs. They should continue to work within the scope of practice of their supervising physician. Insurers also need to be better educated about the role and capabilities of the PA and the appropriate systems for reimbursement for services provided.

The American Academy of Physician Assistants should work with the American Association of Health Plans as well as other groups to educate payers about PAs. Coverage for counseling and patient education should be advocated to payers.

Politics

Nursing—Better articulate the differences between PAs and other nonphysician providers, such as NPs. Better articulate why the PA profession is unique with its basis in the practice of medicine and its rejection of independent practice. Distinguish what makes the PA profession different but not necessarily better.

Physicians—To overcome the increasing concerns of organized medicine, make and continue strategic alliances that help the profession develop and grow. Continue to build stronger strategic alliances with professional groups, such as the American Medical Association, the American Association of Family Physicians, and the American Academy of Pediatrics.

References

2. Ibid., Chapter 2.
3. Ibid., Overview.

12. Ibid.


The opinions and recommendations expressed are those of the workgroup and do not reflect the position of the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services.

The recommendations expressed in the appendix are those of APAP and do not reflect the position of the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services.