CHAPTER SEVEN

Reform #6: Strategically Enhance the Supply of Medical Care While Ensuring Innovation

Principal Features of Reform #6: Strategically Enhance the Supply of Medical Care While Ensuring Innovation

- Stimulate and publicize private retail clinics staffed by nurse practitioners and physician assistants and minimize obstacles and unnecessary regulatory burdens
- Encourage streamlined training programs for physicians and abolish power of medical specialty societies and other administrative bodies that artificially restrict the supply of trained specialists and inhibit competition
- Loosen the scope of practice restraints on nurse practitioners and physician assistants
- Institute national physician licensing via state reciprocity
- Repeal innovation-limiting ACA taxes on medical devices and brand-name drugs
- Streamline the bureaucracy of the Food and Drug Administration (FDA) with regard to device and drug approvals
- Implement strategic immigration reforms to target high-skilled foreign workers and facilitate longer-term visas for highly educated immigrants

Challenges to health care access cannot be met without strategically modernizing the supply and delivery of medical care. Private sector clinics owned by pharmacies and staffed by nurse practitioners and physician assistants can provide routine primary care, including administering flu shots, monitoring blood

pressure, conducting blood tests, and dispensing inexpensive drugs. In a 2011 review, researchers found that eleven medical conditions (outside of preventive care and immunizations) accounted for 88 percent of acute care visits to retail clinics; all the treatments involved relatively low medical costs.[1] Care initiated at retail clinics is 30–40 percent cheaper than similar care at physician offices and about 80 percent cheaper than at emergency departments.[2] Patients seek care at these clinics for several reasons, particularly convenience (that is, extended hours, no need for appointments, and convenient locations), low-cost services, short wait times, and transparent pricing;[3] they have generally reported high levels of satisfaction with their care. Accenture estimates that retail clinics can potentially save hundreds of millions of dollars per year while increasing neighborhood access to routine primary care.[4] While private ownership by stores or pharmacies is common, an emerging trend is for independent retail clinics to develop formal relationships with hospital systems or physician groups. The use of such clinics increased tenfold between 2007 and 2009[5] and continues to grow 15 percent annually. The percentage of large employers providing benefits covering retails clinics nearly doubled between 2008 and 2009. Nearly all accept private insurance (97 percent) and Medicare fee for service (93 percent),[6] but only 60 percent accepted traditional Medicaid.

The key to incentivizing the proliferation of these clinics may rest on eliminating government and special interest obstacles to their use. Retail clinics should not be held to higher standards or more burdensome documentation than other health care clinics. Credentialing requirements for insurance reimbursement should be simplified. In addition, states should follow the recommendations of the Institute of Medicine[7] and remove outmoded scope-of-practice limits and politically based practice restrictions on nurse practitioners and physician assistants, starting first with the dozen states categorized as having "restricted practice" regulations.

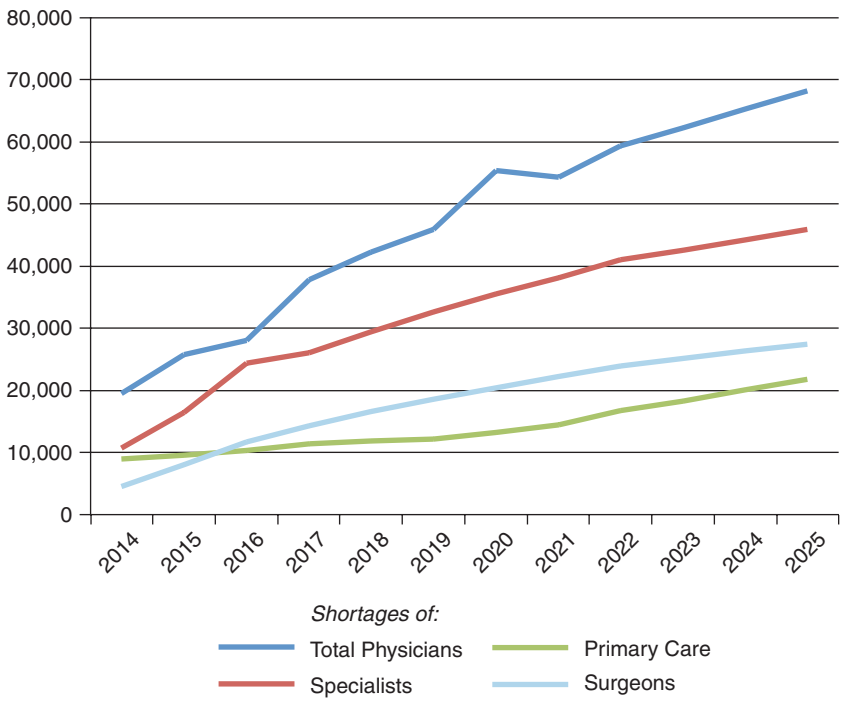

FIGURE 7.1. Projected Physician Shortages, by Field and Year, Median Ranges.
The projected shortages of specialists and surgeons exceed the projected shortage of primary care doctors.
Source: IHS Inc., "The Complexities of Physician Supply and Demand: Projections from 2013 to 2025," Report Prepared for the Association of American Medical Colleges, March 2015, https://www.aamc.org/download/426242/data/ihsreportdownload.pdf?cm_mmc=AAMC-_-ScientificAffairs-_-PDF-_-ihsreport.

States should also modernize physician licensing. Nonreciprocal licensing by states unnecessarily limits patient care, especially as telemedicine proliferates. It is also time to relax tight limits to physician supply that have stagnated medical school graduation numbers for almost forty years and bring to light the strictly controlled residency training practices in place for decades. And increasing physician supply is not only necessary for primary care. Almost two-thirds of the doctor shortage of 124,000 projected for the year 2025 will be in specialist areas, not in primary care[8] (Figure 7.1). Residency training programs still find it extraordinarily difficult to increase the number of their trainees, even when

paying fully for the additional residency positions. Medical societies that set restrictive quotas harm consumers by artificially limiting the supply of doctors and consequently restricting competition among doctors. These anticonsumer practices need to be open to public scrutiny and abolished.

In reality, virtually all patients with serious diseases today are cared for by specialists. For seniors, visits to specialists have increased from 37 percent of visits two decades ago to 55 percent today.[9] And that is appropriate, because specialists are the doctors who have the necessary training and expertise to use the complex diagnostics, new procedures, and novel drugs of modern medicine. To increase the supply of doctors who are trained to use advanced technology and to ensure clinical innovation, we must keep attracting top students into medicine. Specific estimates vary, but while the direct payments for malpractice amount to less than 1 percent of health spending, if one includes the $45 billion in costs of defensive medicine, the total tallies 2.4 percent of health care spending, or more than $55 billion per year.[10] Therefore, we need to rein in malpractice lawsuits that waste money and discourage pursuit of careers in top specialties and encourage streamlined training when possible. Then, let us add common sense—it would be destructive to artificially determine salaries by government price fixing for those who have the most valuable and unique expertise. Price transparency and more consumer empowerment, prompting competition among providers, more effectively sort out these issues.

Perhaps the most insidious consequence of the ACA is the threat to innovation in drugs, devices, and medical technology—the tools that streamline diagnosis, ensure safer treatment, and save lives. The importance of continuing the stream of new medical technology and highly specialized, targeted treatments cannot be overstated, and, we should note, the overwhelming majority of the world's health care innovations occur in the United States (Figures 7.2 and 7.3; Table 7.1). These innovations include groundbreaking drug treatments, surgical procedures, medical devices,

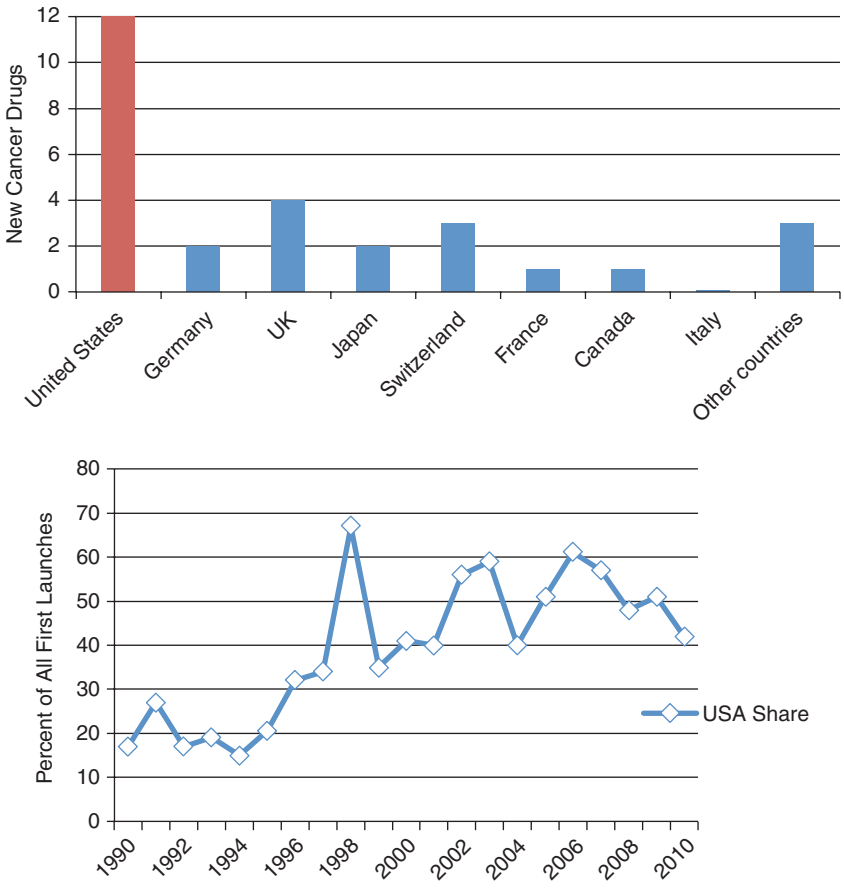

FIGURE 7.2. (*top*) First Launches of New Cancer Drugs by Country, 1995–2005; (*bottom*) US Share of First Launches of New Active Substances, World Market by Year, 1990–2010.
The United States has been the dominant initiator of new drug launches, including new cancer drugs, originating about half of the entire world's new active substances for almost two decades.
Sources: (*top*): B. Jonsson and N. Wilking, "Market Uptake of New Oncology Drugs," *Annals of Oncology* 18, suppl 3 (2007): iii2–iii7, doi:10.1093/annonc/mdm099; (*bottom*): US Food and Drug Administration, "FY 2011 Innovative Drug Approvals," November 2011, http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/UCM278358.pdf.

patents, diagnostics, and much more. A recent *R&D Magazine* survey of research and development (R&D) leaders from sixty-three countries ranked the United States No. 1 in the world for health care innovation.

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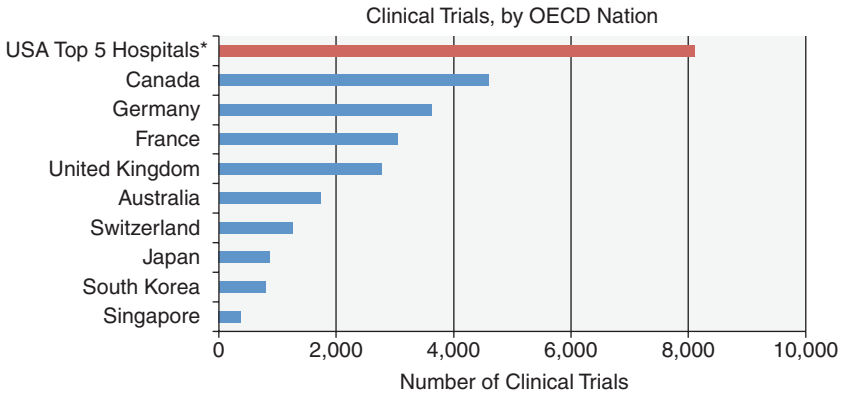

FIGURE 7.3. Clinical Trials, by OECD Nation.
The top five US hospitals conduct more clinical trials than any OECD nation.
Note: *Top five US hospitals as ranked by *US News and World Report*, 2007.
Source: McKinsey Global Institute, "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More," December 2008, http://www.mckinsey.com/insights/health_systems_and_services/accounting_for_the_cost_of_us_health_care.

But that environment is changing. Growth of total US R&D expenditures from 2012 to 2014 averaged only 2.1 percent, down from an average of 6 percent over the previous fifteen years.[11] Although the slowdown is partly attributable to the weak economy since the 2008 financial crisis, it has been exacerbated by Obamacare's new taxes and regulations. According to CBO estimates, the law will impose more than $500 billion in new taxes over its first decade to help pay for its insurance subsidies and Medicaid expansion. These taxes include significant ones on key health care industries, including manufacturers of medical devices and drugs and their investors. Because of the Obamacare tax burden, small and large US health care technology companies are moving R&D centers and jobs overseas. Already a long list of such companies—including Boston Scientific, Stryker, and Cook Medical—have announced job cuts and new centers overseas for R&D, manufacturing, and clinical trials.

Bureaucracy at the FDA is also hindering medical technology and drug development. Developing new drugs now takes about fourteen years and costs more than $2.5 billion.[12] According to a

TABLE 7.1 Major Medical Innovations and Country of Origin

Rank	Technology	Description	Country of Origin
1	Magnetic resonance imaging	Noninvasive diagnostic imaging	USA, UK
	Computed tomography		USA, UK
2	Angiotensin-converting enzyme inhibitors	Drugs for hypertension and heart failure	USA
3	Balloon angioplasty	Minimally invasive surgery to unblock arteries	Switzerland
4	Statins	Cholesterol-reducing drugs	USA, Japan
5	Mammography	Breast cancer detection	Indeterminate
6	Coronary artery bypass graft surgery	Surgery for heart failure	USA
7	Proton pump inhibitors	Antiulcer drugs	Sweden, USA
8	Selective serotonin reuptake inhibitors	Antidepressant drugs	USA
9	Cataract extraction and lens implant	Eye surgery	USA
10	Hip replacement	Mechanical prostheses	UK
	Knee replacement		Japan, UK, USA

Source: Based on V. Fuchs and H. Sox, "Physicians' Views of the Relative Importance of 30 Medical Innovations," *Health Affairs* 20 (2001): 30–42.

2010 survey of more than two hundred medical technology companies, delays for approvals of new devices are now far longer than in Europe.[13] In the European Union—not exactly known for minimizing red tape—it takes seven months on average to gain approval for low- to moderate-risk devices. In the United States, FDA approval time averages thirty-one months. PricewaterhouseCooper's 2011 Innovation Scorecard for medical technology found a worsening in the United States over the past five years. The report stated that "although the United States will hold its lead, the country will continue to lose ground during the next decade."[14] Meanwhile, emerging nations such as India and China have significantly improved their own environments for innovation and entrepreneurs.

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What can be done to reverse these damaging trends? First, strip back the heavy tax burdens on industries and investors that inhibit innovation, starting with repealing the ACA's $24 billion medical device excise tax and the $30 billion tax on brand-name drugs. Repeal the Obamacare investment tax to restore tax incentives for essential funding of early stage medical technology and life science companies. And simplify processes for new device and drug approvals so that the FDA becomes a favorable rather than an obstructionist environment for life-saving and cost-saving discoveries, as well as a facilitator for the availability of lower-cost generics.

Finally, intelligent immigration reforms are needed to encourage educated, highly skilled entrepreneurs to stay in the United States. Many of the best and brightest who come to the United States to study science, technology, engineering, and math—subjects crucial to health care innovation—are now choosing to return to their home countries after they finish their studies. In contrast to a decade ago, when from 66 percent to more than 90 percent of foreign students studying in the United States remained here after they completed their studies, only 6 percent of Indian, 10 percent of Chinese, and 15 percent of European students expect to make America their permanent home today.[15] Although some of this shift is undoubtedly the result of improving opportunities in those students' home countries and other incentives for them to return home, many graduates want to remain in the United States but are unable to do so. Lawmakers should take a fresh look at easing counterproductive immigration restrictions. New skills-based visa programs should be instituted that specifically target highly educated individuals, particularly students completing American university graduate-degree programs in the areas of science, technology, engineering, and math.