



PHYSICIAN SHORTAGES: BETTER UTILIZATION OF ADVANCED PRACTICE REGISTERED NURSES IN PALLIATIVE MEDICINE COULD PROVIDE RELIEF

JUNE 2023

Physician Shortages: Implications for Hospice and Palliative Sector

A fast-growing and aging U.S. population is posing concerns for physicians' ability to meet patient demand in the future. Current and future population estimates from the U.S. Census Bureau indicate a projected growth of 34.8 million people from 2019 to 2034. An estimated 66% of this growth is attributed to people aged 65 or older.¹ As such, physician shortages are especially concerning in the hospice and palliative care sector. As the population ages, the need for a higher volume of care and more specialized expertise will grow.

Considering this factor, Florida's residents are especially vulnerable because of the state's demographic makeup. Florida has a larger percent of seniors than the U.S. due to its popularity as a permanent residence for retirees. An estimated 17 percent of the U.S. population is comprised of people aged 65 or older, while Florida's estimated share is 21 percent.² While current shortages are already apparent, future projections of physician supply and demand growth suggest that the problem will worsen with time.

In Florida, physician demand is projected to exceed supply by at least 20 percent in nearly every Medicaid region by 2035. A report commissioned by the Florida Safety Net Hospital Alliance and the Florida Hospital Association derived this estimate, as well as a statewide physician shortfall of about 18,000 physicians by 2035. This estimate includes nearly 6,000 primary care physicians who practice "family medicine, general internal medicine, pediatric medicine, and geriatric medicine."³

In addition, the growing number of Americans living with chronic illnesses --- and new-found recognition of the benefits palliative care offers --- has ratcheted up the demand for physicians specializing in hospice and palliative medicine (HPM). The U.S. Centers for Disease

Control and Prevention (CDC) estimates that 6 in 10 adults suffer from a chronic disease.⁴

An unmet need for health care ultimately hurts both patients and their providers. There is already a shortage of physicians to meet patient demand in the U.S., and supply projections indicate that the physician workforce growth rate will not be able to keep up with a fast-growing population. Considering the aging U.S. population, physician shortages are particularly concerning for patients who already do, or soon will require, hospice or palliative care. These individuals are mostly comprised of the elderly population and those suffering from chronic and serious illnesses. Florida, being a popular residence for retirees and elderly people, will suffer if the physician gap fails to be bridged.

Evolution of Hospice and Palliative Care

The HPM specialty focuses on the easing of pain and maintaining comfort for patients with chronic and serious illnesses, or those nearing the end of their life. A patient is eligible for hospice care if they have a terminal diagnosis, but palliative care is also available to anyone suffering from a chronic and serious illness. Two essential skills of providing high-quality and cost-effective palliative care are communication and pain management.

The hospice and palliative care sector has garnered legitimacy in the medical field since the "hospice movement" of the 1960s. This movement brought to light the need for specialized care aimed at minimizing suffering and improving the quality of life for people with chronic and serious illnesses, or at the end stages of life. In 2006, HPM was recognized as a medical specialty. As a result, access to this type of care and education for providing it has expanded.⁵ From 2000 to 2020, the share of hospitals that offer palliative care programs rose from 25 percent to 83 percent.⁶ In addition, several accredited medical schools have adopted fellowship programs and elective courses related to HPM.

1 Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034," June 2021.

2 United States Census Bureau, American Community Survey (ACS) 1-Year Estimates 2021.

3 Florida Medical Association, "Florida's physician shortage: It's not just primary care and rural areas," retrieved from https://www.flmedical.org/florida/Florida_Public/News/2022/Florida%E2%80%99s_physician_shortage.aspx, accessed on March 10th, 2023.

4 U.S. Centers for Disease Control and Prevention, "Chronic Disease in America," retrieved from <https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm>, accessed on March 6th, 2023.

5 Debra Bradley Ruder, "From Specialty to Shortage," retrieved from <https://www.harvardmagazine.com/2015/03/from-specialty-to-shortage>, accessed on March 3rd, 2023.

6 Center to Advance Palliative Care, "Growth of Palliative Care in U.S. Hospitals: 2022 Snapshot (2000-2020)," 2022.

As of the 2020-2021 school term, there were 156 fellowship programs in the U.S.⁷

Shortage of Physicians in Hospice and Palliative Medicine

Although this growth in facilities and physicians is resulting in more patient access to comfort-based care, the demand for it is growing faster. The U.S. population is aging, and this poses issues for patients and care providers alike. Today, “Baby Boomers” are between ages 59 and 77. Florida holds a relatively large elderly population, as it is a popular place for retirees to reside. There are nearly five million Baby Boomers living in Florida today; many of these individuals soon will, if not already, require more specialized medical care, including palliative care.⁸ Without enough trained clinicians to address the shortage, high-quality care will be inaccessible to many.

An aging population also threatens the HPM physician workforce stability. According to a 2021 report by the Association of American Medical Colleges (AAMC), more than 2 in 5 physicians would be 65 or older within the next decade.⁹ Physicians that specialize in HPM will be phasing into retirement in the coming years, when they are needed most. The sentiment of “burnout” shared by clinicians in the palliative care sector will also likely prompt these specialists to retire at the usual age, if not sooner. In a clinician survey conducted at Duke University, 33.6 percent of palliative care physicians reported experiencing burnout in their position. This was the highest percent reported among all palliative care workers, including nurses, social workers, and other staff.¹⁰

These issues suggest that hospice programs will continue to face the stress of demanding caseloads because they lack the manpower to provide quality care. When demand inevitably grows, physician burnout could worsen. The American Academy of Hospice and Palliative Medicine (AAHPM) recognizes this problem and has previously proposed legislation to support interdisciplinary education for hospice and palliative care, and support fellowship training of the HPM physician workforce.¹¹

In the presence of an aging U.S. population, the looming shortage of hospice and palliative care physicians is concerning. A study published

in the American Journal of Medicine estimated only a one percent growth in the HPM physician workforce over 20 years. Meanwhile, the number of patients eligible to receive palliative care is expected to grow by 20 percent.¹² This shortage is sure to adversely affect individuals seeking a palliative care facility to provide them comfort through chronic and serious illness and the end of their lives.

Better Utilization of APRNs in Palliative Medicine

Also suffering are the nation’s palliative care physicians --- the high demand for physicians in this specialty is not being met, and all workers in these facilities are feeling the effects of it. This problem is only expected to worsen with time --- as “Baby Boomers”, the second largest generation, grow older --- and clinicians remain at odds about which solution to implement.

One proposed solution to this shortage is lightening physicians’ caseloads by employing Advanced Practice Registered Nurses (APRNs) to attend to patients on their own. Given more autonomy, APRNs would assume some responsibilities currently appointed to physicians. This action would be instrumental in addressing shortages for all fields of medicine, but especially for hospice and palliative care facilities, which are projected to have a large influx of patients in the coming years.

In Florida, however, this solution cannot currently be implemented without a change to Florida Statutes. Under the APRN Autonomous Practice Act, these practitioners are permitted to admit and manage patient care, discharge patients from a healthcare facility, perform all medical certifications (excluding medical marijuana), and prescribe the same drugs in the same quantities as physicians. The Autonomous Practice Act in Florida Statutes states:

“(a) An advanced practice registered nurse who is registered under this section may:

1. Engage in autonomous practice only in primary care practice, including family medicine, general pediatrics, and general internal medicine, as defined by board rule.” – Section 464.0123 (3), Florida Statutes.¹³

Because this subsection does not explicitly include hospice and palliative care as a sector of authorized autonomous practice, registered APRNs are currently precluded from conducting the following practices in hospice and palliative care facilities without physician supervision:

1. Admitting, managing care of, and discharging a patient from a medical facility;
2. Signing a Death Certificate;
3. Signing a Do Not Resuscitate Order (DNRO); and
4. Prescribing opioids for more than a seven-day supply.

7 American Academy of Hospice and Palliative Medicine, “Hospice and Palliative Medicine Fellowship Programs,” October 2020.

8 United States Census Bureau, American Community Survey (ACS) 1-Year Estimates Microdata Sample 2021.

9 Association of American Medical Colleges, “Aging patients and doctors drive nation’s physician shortage,” retrieved from <https://www.aamc.org/news-insights/aging-patients-and-doctors-drive-nation-s-physician-shortage>, accessed on March 1st, 2023. This report was generated primarily using data collected in 2019.

10 Kamal, Arif H. “Policy Changes Key to Promoting Sustainability and ... - Health Affairs.” Health Affairs, June 2019, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00018>.

11 American Academy of Hospice and Palliative Medicine, “Expanding the Hospice and Palliative Care Workforce,” retrieved from <https://aahpm.org/issues/workforce>, accessed on March 1st, 2023.

12 The American Journal of Medicine, “Future of the Palliative Care Workforce: Preview to an Impending Crisis,” retrieved from [https://www.amjmed.com/article/S0002-9343\(16\)30962-7/fulltext#secsectitle0025](https://www.amjmed.com/article/S0002-9343(16)30962-7/fulltext#secsectitle0025), accessed on March 22nd, 2023.

13 §464.0123 Fla. Stat. (2022).

The omission of these practice authorities does not prohibit APRNs from performing them in the primary care sectors listed in Florida law, but it imposes limitations on APRNs' autonomous practices if they begin working in a hospice or palliative care facility. This technicality is preventing hospice and palliative care facilities in Florida from using APRNs to the full extent of their professional qualifications. Amending Section 464.0123(3), Florida Statutes, to remove the existing limitations on APRNs' autonomous practices if they begin working in a hospice or palliative care facility would more fully utilize APRNs and alleviate physician shortages affecting the state.

A Cost-Effective Solution

The APRN workforce has been experiencing substantial and consistent growth for the past 20 years, and this growth is expected to continue. In 2018, there were about 234,000 licensed APRNs in the U.S.¹⁴ By 2020, there were 290,000.¹⁵ The Bureau of Labor Statistics projects 2021-2031 growth of 40% for the occupation, and indicates this growth is much higher than the average occupation trajectory.¹⁶

With continued growth, these practitioners could significantly alleviate physician shortages and improve patient access to all types of health care. Employing them in hospice and palliative care facilities would ease specialists' patient loads by delegating some time-consuming responsibilities to the APRNs. Having more practitioners to carry out these duties could also result in new palliative care programs being opened, giving more people in need access to comfort-based care.

In addition to the expanding network of APRNs, their cost-effectiveness relative to physicians is notable. Nurse Practitioners (NPs) are a subset of APRNs who practice in a range of disciplines, (geriatric, psychiatric, pediatric, neonatal, etc.) but they largely serve in primary care settings. There is ample evidence that demonstrates the cost-saving utility of a NP, and confirms patient outcomes do not suffer from NP-led care. The current mean annual wage of a family medicine physician in the U.S. is about \$236,000, while that of NPs is \$118,000.¹⁷ A 2004 study of primary care practices found that the labor costs associated with practitioners and visits were lower in practices that utilized more NPs and physician assistants (PAs).¹⁸ NPs were also found to achieve similar patient outcomes as physicians when operating under similar levels of authority. Another study

compared the outcomes of NP patients to those of physician patients and found no significant differences in overall patient satisfaction, physiological tests, health status, and health service utilization.¹⁹

Aside from reduced costs of compensation, the use of costly measures and procedures is lower among NP patients. This is especially true in the case of older patients. A study examining NP management of older patients concluded that combined physician-NP medical teams achieved "lower rates of emergency department transfers, shorter hospital lengths of stay and fewer specialty visits" than that of physician-only teams.²⁰ By adding more of these practitioners to palliative care teams --- with the same independence they are granted in primary care settings --- fewer physicians would be needed to attend to patients' needs. This will ultimately be a cost-saving measure.

Delegating more responsibilities to APRNs would certainly reduce the workload of their physician partners, as well as minimize costs for hospice and palliative care programs. The most compelling reason, however, for granting more autonomy to APRNs in hospice and palliative care is that their education and training fully qualifies them for it. Licensed APRNs must earn a master's or doctoral degree in their chosen field of medicine, and then acquire a certification in that field. As far as training is concerned, APRNs receive a combination of instruction based on the nursing and physician models. Their training in the nursing model equips them with knowledge of holistic health and well-being, two skills that are pertinent to providing comfort-based care in hospice settings.²¹

Conclusion and Recommendations

Fully utilizing the APRN workforce has the potential to significantly mitigate current and future physician shortage issues, including limited access to health care and worsening patient outcomes due to physician burnout. This solution is particularly important to consider in the case of hospice and palliative care facilities, where an unmet demand for care has persisted. These needs will only continue growing amid an aging population. APRNs in Florida are currently prohibited from performing some largely administrative, but essential tasks in hospice and palliative care due to the omission of this field of medicine in Florida Statutes.

There are three primary reasons why the Autonomous Practice Act should be amended to include hospice and palliative care, granting APRNs more autonomy in palliative care settings:

1. **The APRN workforce is expanding.** The draw of this rewarding profession is gaining traction, and the current high-growth status of

14 Yale University School of Nursing, "Filling Critical Gaps in Primary Healthcare: Advanced Practice Registered Nurses Meeting the Challenge," retrieved from <https://nursing.yale.edu/news/filling-critical-gaps-primary-healthcare-advanced-practice-registered-nurses-meeting-challenge>, accessed on March 6th, 2023.

15 Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034," June 2021.

16 The Bureau of Labor Statistics, "Occupational Outlook Handbook," retrieved from <https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>, accessed on March 3rd, 2023.

17 Bureau of Labor Statistics, "May 2021 National Occupational Employment and Wage Estimates," retrieved from https://www.bls.gov/oes/current/oes_nat.htm#29-0000, accessed on March 8th, 2023.

18 American Association of Nurse Practitioners, "Nurse Practitioner Cost Effectiveness," retrieved from <https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioner-cost-effectiveness>, accessed on March 8th, 2023.

19 Mary O. Munderinger; et al., "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," retrieved from <https://jamanetwork.com/journals/jama/fullarticle/192259>. Accessed on March 27th, 2023.

20 American Association of Nurse Practitioners, "Nurse Practitioner Cost Effectiveness," retrieved from <https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioner-cost-effectiveness>, accessed on March 8th, 2023.

21 Yale School of Nursing, "Filling Critical Gaps in Primary Healthcare: Advanced Practice Registered Nurses Meeting the Challenge," retrieved from <https://nursing.yale.edu/news/filling-critical-gaps-primary-healthcare-advanced-practice-registered-nurses-meeting-challenge>, accessed on March 10th, 2023.

the workforce is predicted to continue in the next decade. In this, there is potential to improve patient access to all types of health care, especially palliative care. With an aging population, undoubtedly more Americans will need specialized hospice and palliative care in the coming years. Future projections of physician supply alone do not indicate this demand could be met, but supplementing physicians with APRNs on medical teams would begin to address shortages.

2. Utilizing Nurse Practitioners (NPs) is associated with lower costs of care.

The education, compensation, and use of costly procedures in practice is lower among NPs than that of physicians. Cost analyses indicate that medical facilities can achieve lower expenditures from utilizing more NPs and PAs. With current average salary estimates, a practice could employ two NPs for the cost of hiring one physician. Additionally, NP-led practices conduct fewer costly procedures than physician-led practices, while achieving the same or substantially similar patient outcomes.

3. The education and training of APRNs fully prepares them to perform these tasks.

A licensed APRN must earn a master's or doctoral degree in their chosen field of medicine, and then acquire a certification in that field. APRNs are trained in the nursing model, but also receive advanced practice training that combines the teachings of nursing with curricula from the physician model. The combination of these skills, and especially the patient-centered nursing approach APRNs learn, fully qualifies them to perform the duties that Florida law currently precludes.

For these reasons, Florida TaxWatch recommends that section 464.0123(3) of Florida Statutes be amended so that APRNs' autonomous practice authority in primary care is extended to hospice and palliative care. This inclusion will simply allow APRNs already performing certain duties in primary care practice to then utilize these skills in a palliative care setting. This is a step towards addressing physician shortage problems in Florida. Taking measures such as this one will improve patient access to hospice and palliative care, supporting a higher quality of life for Floridians with chronic and serious illness or at the end of life.



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