# Increasing Access to Health Care

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Poor people often have difficulty accessing good health care. They tend to live in areas underserved by physicians and medical facilities, and have problems that make them unable to pay for care. More often than the general population, they distrust hospitals, delay treatment and do not follow care instructions. In addition, they are disproportionately affected by chronic illnesses, including heart disease and diabetes.[1]

Though federal, state and local governments subsidize some health care services for the poor, government regulations raise the cost of medical care delivered by public programs and private providers. Regulations also limit service availability.

Regulatory relief is the key to increasing access to health care for underserved and low-income consumers. If health care providers serving these individuals were exempted from state and federal regulations that dictate how care must be provided, it would lower the costs of services. Additionally, more health care providers would be attracted to medically underserved areas and populations if they were free to change services to make them more accessible and more affordable. This is particularly important in rural areas, for the uninsured, and for illegal immigrants with few legal health care options.

## Government Efforts to Increase Access to Care

There are many state and federal programs that attempt to solve the problem of limited access to care.[2] Nevertheless, many individuals remain unserved or underserved.

**Medicaid.** Medicaid provides medical, and in some cases dental, insurance for individuals who are poor or disabled, with funds from the federal government and the states.[3] But low reimbursement rates in some states make it hard for patients to find a primary care physician.[4]

**Financial Incentives to Health Care Professionals.** State and federal governments offer health care providers bonuses and education loan repayment to attract them to underserved areas. For example, in Health Professional Shortage Areas the federal government offers a 10 percent bonus to physicians to serve Medicare participants.[5] However, two studies have found the bonuses are not sufficient to attract physicians to work in rural areas.[6]

Some states and the U.S. Department of Health and Human Services' National Health Service Corps offer scholarships and loan repayment to physicians, nurse practitioners, physician assistants and certified nurse midwives willing to practice in underserved areas.[7]

**Community Health Workers.** Federal and state governments fund community health workers in states with underserved and remote populations. Community health workers improve access to care by serving as intermediaries between patients and health care providers. They translate, counsel, educate, refer and provide some direct services, such as blood pressure screening.

In Alaska, for example, villages select individuals to be trained as community health aides. Once trained, they refer patients to midlevel clinicians and physicians, regional hospitals and the Alaska Native Medical Center.[8] There is some empirical evidence linking community health workers to positive health outcomes in low-income and minority populations.[9]

**Community Health Centers.** Federally Qualified Health Centers (FQHC) and so-called FQHC Lookalikes are community health centers that receive federal grants. Funding for these centers has more than doubled in the last decade. Community health centers make extensive use of nonphysician clinicians including nurse practitioners, physician assistants and nurse midwives.[10] The clinicians who serve areas or populations the federal government has designated as Medically Underserved are eligible for enhanced Medicare and Medicaid reimbursement, among other benefits.[11] Rural Health Clinics that meet federal requirements also qualify for extra reimbursement. They must use a team approach, using both physicians and nonphysician clinicians to provide care.

**Critical Access Hospitals.** Rural populations are often poor, covered only by Medicaid, and have access only to a federally funded critical access hospital. Doctors who serve such rural populations are usually employees of these facilities. Medicare's Rural Hospital Flexibility Program subsidizes Critical Access Hospitals for emergency care in rural areas. Given the difficulty of attracting physicians to rural areas, Medicare allows nonphysician clinicians to staff these facilities, supervised remotely by a physician. The nonphysician clinician may be a physician assistant, nurse practitioner, clinical nurse specialist and in some cases, a nurse. Most states with large rural populations allow this type of set-up, but some states still do not allow nonphysician clinicians to work without a physician on site.

**Telemedicine.** Federal funds have been allocated to telemedicine as a way of getting care to rural populations. For example, the Federal Communications Commission funds the California Telehealth Network, which is designed to connect providers in rural and underserved areas to a broadband network that will be used exclusively for health care.

However, broadband access alone is insufficient, as there must be clinicians at the other end. For instance, clinic managers in California's medically underserved San Joaquin Valley have difficulty finding specialists willing to treat their predominantly Medicaid-insured patients, given Medi-Cal's low reimbursement rates.[12]

**Increasing the Number of Health Professionals.** International medical graduates have been recruited by state and federal agencies to fill the gap in communities where physician-population ratios are low. States use the J-1 Visa waiver program to attract international medical graduates, as does the National Health Service Corps.[13] Also, state medical schools have been given the task of increasing the number of graduating physicians who practice within the state. Many programs now screen applicants in search of individuals likely to serve rural or otherwise disadvantaged populations, and some have been successful.[14]

## Who Provides Care?

One of the goals of the Patient Protection and Affordable Care Act (ACA) is to increase the number of individuals covered by private health insurance or enrolled in public health programs like Medicaid. This will significantly increase demand for primary care physicians. On average, the newly insured will nearly double their consumption of health care.[15] According to the *Journal of the American Medical Association*, there are 778,000 practicing doctors in the United States.[16] Just under half of them are primary care physicians. Before passage of the ACA in 2010, the Association of American Medical Colleges estimated that an additional 45,000 primary care physicians would be needed by 2020 to keep up with demand. But many patients already experience difficulty accessing primary care, particularly low-income individuals and families.

**Midlevel Clinicians.** In 2004, in addition to physicians (M.D.s and D.O.s), there were more than 240,000 advanced practice nurses and 60,000 physician assistants working in the United States.[17] Studies suggest nonphysician clinicians can competently provide from 60 percent to 90 percent of primary care.[18] Nurse practitioners and physician assistants have more medical training than registered nurses and are able to deliver some routine medical care without the direct supervision of a physician, including: prescribing or renewing prescriptions for most drugs, ordering blood tests, performing routine medical examinations, monitoring chronic conditions, counseling patients about prevention, and treating colds, sore throats and the flu.

Despite the emphasis on primary care in their education, many physician assistants work in specialty practices that are not specifically licensed by the states.[19]

**Nurses and Other Caregivers.** Based on 2004 data, there were 2.9 million registered nurses (RNs) in the United States, including those in advanced practice, and about 750,000 licensed practical and vocational nurses (LPNs and LVNs). In addition, there are millions of unlicensed aides and orderlies holding a variety of certifications.[20, 21] For example, emergency medical services (EMS) employ many trained professionals and volunteers who can competently provide

care. The EMS workforce in the United States includes approximately 600,000 emergency medical technicians (EMTs), 142,000 paramedics and more than 1 million firefighters (many of whom are cross-trained in EMS). EMS providers include First Responders who have about 40 hours of training, EMT-Basics who have about 110 hours of training, EMT-Intermediates who have about 200-400 hours of training, and Paramedics who have 1,000 or more hours of training.[22] Certification and scope of practices varies from region to region. Additionally, there are military-trained medics, some of whom seek civilian certifications, although state agencies often don't recognize their service training.[23]

## Barriers to Increasing Health Care Access

Unfortunately, government policies artificially increase demand, raise costs, and limit the availability of care to the poor. Tax subsidies to employer-provided health plans encourage the purchase of policies with low copays. The result is increased consumption, some of which may be attributed to physician-induced demand. Regulations restrict the number of health care facilities and limit who can provide health care. These factors drive the cash price of health care higher than it otherwise would be. As a result, the working poor who do not qualify for Medicaid or employer-sponsored coverage have difficulty paying for the health care that is available.

**Barrier to Care: Restrictions on Physicians.** Medical licensure for physicians is highly restrictive. A physician must go through an expensive and time consuming process to be licensed in another state. By contrast, Certified Public Accountants are not licensed, but are certified by a private organization and are able to practice in any state.

Many states have restrictions on telemedicine that make it illegal for a physician in one state to consult with a patient in another state without an initial face-to-face meeting. It is also illegal in most states for a physician who has examined a patient from another state to continue treatment of the patient via the Internet. Unless the physician is licensed in the state where the patient resides, he or she may be considered to be practicing medicine without a license.[24]

**Barrier to Care: Restrictions on Nonphysician Clinicians.** Numerous studies have found that the cost of care patients receive from nonphysician clinicians such as nurse practitioners and physician assistants is much lower than the same services performed by a physician, but that the quality is the same.[25]

Unfortunately, nonphysician clinicians are severely restricted in the duties they can perform. For example:

- ⇨ Many states do not allow nurse practitioners to practice independent of physician oversight or collaboration.[26]

⇨ About a dozen states still do not allow nurse practitioners to prescribe Schedule II controlled substances, such as morphine and oxycodone. Alabama and Florida do not allow nurse practitioners to prescribe any controlled substances.[27]

In addition, no state allows physician assistants to practice independently, although it is not uncommon for physician assistants to have relative autonomy, conferring with a supervising physician as necessary. As is the case for nurse practitioners, about a dozen states do not allow physician assistants to prescribe Schedule II drugs. The state of Kentucky does not allow physician assistants to prescribe any controlled substances.[28]

**Barrier to Providing Care: Unnecessary Credentials.** Midlevel medical professions have successfully raised barriers to entry by increasing the amount of education required to obtain a license. For example, some states require new nurse practitioners to obtain a graduate degree. In many instances, the health professions are able to impose higher education requirements (which necessarily raise the cost of education and training) because state licensing laws require individuals to have graduated from accredited training programs, and professional organizations control the accrediting process. Consumers are worse off as a result, particularly those in underserved areas. For example, it does not require an advanced practice nurse, audiologist, or physical therapist with a clinical doctorate to deliver most health care services, but the accrediting organizations have moved in this direction. Opportunities to increase one's scope of practice through on-the-job training and experience are generally missing in the U.S. health care system, although they are keys to success in nearly every other industry.

**Barrier to Providing Care: American Medical Association Reimbursement Codes.** In a process called regulatory capture, organized special interests use the regulatory apparatus to further their own interests.[29] Codes used to determine the reimbursement of health care providers are controlled by the American Medical Association (AMA), which has little interest in designing codes for alternative providers or the use of productivity improving technology, such as e-mail and phone access to physicians or advance practice nurses.[30]

For example, the Current Procedural Terminology (CPT) codes that federal and state programs use to reimburse health care professionals, are controlled by the AMA and restrict who can be reimbursed for performing a given procedure. This has limited the reimbursement of nonphysician clinicians, reducing their ability to contribute to improved patient health. An improved system of codes would both document the contributions of nonphysician clinicians and allow an analysis of their impact on medical outcomes.[31]

Codes also do not reimburse practices for communicating with patients by e-mail. This provides little incentive for medical practices to adopt this efficiency enhancing technology. When Kaiser Permanente gave e-mail access to their patients in Hawaii, office visits fell by 25 percent.[32]

**Barrier to Care: Hospital Associations.** Hospital associations have been equally successful in influencing public policy, limiting competition to protect their market power. State-level certificate-of-need programs were promoted as a way to avoid duplication and save money, but they made it hard to compete with existing facilities. Hospital lobbyists have successfully limited the growth of specialty hospitals that produce efficiencies by focusing on a particular service.[33] State and federal tax codes favor not-for-profit hospitals with tax exemptions that are not available to for-profit entrepreneurs.

**Barrier to Care: Restrictions on Physician-Owned Hospitals.** The 2010 Patient Protection and Affordable Care Act permanently bans new physician-owned hospitals, even though for-profit hospitals are more likely to come up with innovative, efficiency improving ways to restructure services.[34]

**Barrier to Care: State and Federal Laws Inhibiting Beneficial Collaboration.** A U.S. physician practice could easily provide doctor visits in a traditional office, coupled with chronic disease management services from a foreign doctor (by telephone or e-mail) and tests done at a convenient retail clinic, when needed. Yet this service could run afoul of the so-called Stark laws. The federal Stark laws make it illegal for a physician to refer a patient for treatment to a clinic in which the doctor has a financial interest. Nor may a physician reward providers who refer patients to him or to a hospital in which he has a financial interest.

Unfortunately, laws meant to prevent self-dealing and kickbacks also inhibit beneficial collaboration between doctors and hospitals. For instance, the Stark laws could prevent a physician practice from referring a patient with a chronic condition to an affiliated disease management program or prevent him from referring a patient needing minor treatment to an affiliated walk-in clinic.

By limiting compensation arrangements for referrals and collaboration, the Stark laws tend to result in rigid physician group practices that are not particularly convenient or economical for patients.

**Barrier to Care: State Restrictions on the Employment of Doctors.** About one-third of the states have laws banning the "corporate practice of medicine," which prevent corporations from hiring physicians to practice on their behalf.[35] The implication is that a corporate employer might exert undue pressure to skimp on quality in order to increase or preserve profits. These laws ostensibly aim to ensure the quality of medical care, but in practice they inhibit innovative service arrangements.[36] For example, in many states a company may not establish a chronic disease management service and hire physicians to monitor clients.

One-third of the states have passed laws allowing some firms (such as hospitals and health plans) to hire physicians directly to practice on their behalf. In the rest of the states, the laws are either unclear or appear to support or restrict the practice to varying degrees.[37]

## Are These Regulations Necessary?

It is often claimed that medical professions and health care delivery should be highly regulated in order to protect patient health and safety. It is argued that health care is highly technical, consumers are not equipped to judge quality and patients are especially vulnerable and require special protection. Are these concerns valid?

**Does Health Care Require More Regulation than Other Goods?** If there is an economic argument for government intervention in health care, it rests on the idea that consumers cannot identify quality and need assistance. Not everyone buys that premise. In fact, economists who have examined the market for physician services argue that licensing constrains the efficient combination of inputs, limits innovation in how care is provided, and limits innovation in medical education.[38] Of the major health economics textbooks, only one is on the fence with respect to the negative impact of medical professional licensing.[39] A 1963 paper by economist Kenneth Arrow argued for state intervention to offset an information disadvantage consumers have when they buy health care.[40] However, Arrow questioned the ability of state medical boards to assure quality. He acknowledged that existing laws only guaranteed initial training, not continued competence. He was troubled that licensing laws limited the variation in quality that some consumers might prefer. Furthermore, he acknowledged that licensing restricted the supply of medical care. He pointed out the inefficiencies of state laws:

> The licensing laws...exclude all others from engaging in any one of the activities known as medical practice. As a result, costly physician time may be employed at specific tasks for which only a small fraction of their training is needed, and which could be performed by others less well trained and therefore less expensive.[41]

Clearly Arrow's position is not a defense of stringent licensing, as it is often cited.

**Quality Assurance in Health Care.** Many people think that state medical licensing boards are necessary to assure health care quality. Thus, they oppose allowing individuals to take on more tasks, even as their experience and skills increase. But there are other ways to assure quality in health care.[42]

Consumers use private information in selecting health care providers and they would do well under a less restrictive system.[43] Consumers rely on hospital and Health Maintenance Organization (HMO) brand names. When hospitals with strong reputations confer credentials and privileges on particular physicians, consumers count on those physicians' specialty and skills. Health maintenance organizations and other health insurers must also credential physicians in their provider networks to avoid serious liability for adverse events. Most hospitals and HMOs make sure that physicians have medical malpractice insurance which provides yet another level of oversight. Consumers also rely on referrals from other practitioners, friends and family.

Oversight of medical practices actually occurs at the point of care. Hospitals check out every person they hire to make sure their training, experience and skills match the tasks they will be permitted to attempt. Hospitals, health care providers and medical malpractice underwriters have substantially more information about individual practitioners than can be gleaned by relying on state licensing.

Medical professional liability insurance underwriters scrutinize physicians and other clinicians they insure. One way to be sure a clinician has the requisite skills is if she carries malpractice insurance that covers the procedures she performs. If consumers relied on medical malpractice underwriting — which negotiates restrictions on practice for clinicians with problematic records — instead of state licensing, consumers would actually have a greater level of protection.[44]

Medical professional licensing and scope-of-practice rules discourage or prohibit productivity-improving innovations in medical education and health care delivery.[45] Ending state licensing and scope-of-practice restraints would improve access to care by allowing more individuals to use the skills they learn on the job. We know that many nurse practitioners and physician assistants, trained in primary care, end up working in a specialty field for which they have no formal training. Their success in doing so suggests that the protections are not coming from licensing but from concerns, oversight and liability at the point of care.

**The Role of Competition.** State laws and regulations make it very difficult to innovate in providing health care. In other sectors of the economy, regulation is not as prevalent. For example, Wal-Mart has done wonders for families who are poor. Thanks to Wal-Mart's lower prices, families who are poor save hundreds to thousands of dollars a year on everyday purchases. But if state governments regulated product distribution the way they regulate medical care, Wal-Mart never could have put in place the innovations that made its distribution network efficient.

Wal-Mart's success can also be attributed to the fact that consumers were free to leave their old providers and patronize Wal-Mart. If retail purchases were paid for the way much of health care is paid for, with reimbursement for purchases limited to existing state-approved providers, Wal-Mart never could have brought its cost-saving innovations to the retail market.

Finally, the profit motive is important. Wal-Mart was not the only firm trying to improve customer service, but it has been most successful in the ongoing competition to attract customers to retail stores. Looking at the bottom line in an effort to increase profitability forces firms to consider how to lower costs or improve the quality of their product.

In health care, providers fail to innovate because they are protected from the competition of pioneering entrepreneurs. Reimbursement is tied to existing methods of providing care, leaving little incentive to improve existing practices.

## Solutions for Medically Underserved Populations

Some federal and state programs that subsidize providers in poor communities allow nurse practitioners and others to perform more primary care tasks. There have been some private sector innovations such as miniclinics located in retail stores, but much more is possible.

The key to expanding access to care is to free medically underserved populations from regulations that limit access to care. The criteria for allowing providers to operate free of many regulations could be one that is already in place: the federal government's criteria for Medically Underserved Areas (MUAs) and Populations (MUPs), based on the Index of Medical Underservice (IMU).[46] The IMU involves four variables — ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

Some of these areas may include communities, as in California, that have large numbers of illegal immigrants. Without regulatory reform, individuals in these communities must rely on underground care providers. Alternatively, sick individuals show up at emergency rooms when their illness has become severe enough to require hospital treatment.

Following are examples of the kinds of constraints that should be lifted.

**Make Scope-of-Practice Regulations Less Restrictive.** One way to increase access to care is to exempt nurse practitioners, physician assistants, nurse midwives and other midlevel clinicians from state laws that limit their scope of practice if they serve low-income or rural populations. Studies have demonstrated that there are no adverse effects, and even some beneficial effects, in allowing nurse practitioners to provide primary care to underserved populations.[47]

Some states with large underserved populations have legislatively expand the scope of practice of nonphysician clinicians, increasing the autonomy of advanced practice nurses, including nurse practitioners and nurse midwives.[48] They allow health care professionals to provide primary care and prescribe certain drugs independent of physician supervision. Numerous studies suggest they are very effective substitutes for physicians in this capacity, yet in many states it remains illegal for them to provide care independent of physician oversight.[49]

For example, in order to better serve its rural populations, Alaska has set aside licensing laws that in other states restrict access to care. Dental health aid therapists, for instance, practice in remote areas where dentists rarely visit. The allowable scope of practice can be rewritten by the supervising dentist as therapists become more knowledgeable and gain skills through continuing education.[50]

*Dental Services.* Researchers considering the challenge of getting oral health services to individuals in rural and institutional settings in the United States have

proposed new roles for existing health care providers, such as expanding the role of dental hygienists in providing care. They also advocate new education and workforce models to include new types of providers — such as dental health aid therapists and dental therapists.[51] To expand access to preventative care, they suggest reimbursing physicians, nurse practitioners and physician assistants who apply fluoride varnishes during well-child exams.

*Pharmacists.* Expanding the scope-of-practice of pharmacists would also increase access to services in medically underserved communities. In 2007 the U.S. Food and Drug Administration proposed adding a new class of behind-the-counter drugs consumers could buy after consultation with a pharmacist, including drugs for migraine headaches and drugs to improve cholesterol levels. Other countries, including Britain, already use this system to dispense drugs that do not require sophisticated diagnosis and prescription. Pharmacists could also counsel patients with chronic diseases on appropriate drug use and disease management. For instance, most states already allow pharmacists to initiate and monitor drug therapy for diabetics.[52] Allowing these services in all underserved communities could lower costs and increase access to care.

**Reform Education and Training Requirements.** State education and training requirements are stricter than necessary. An exemption from state laws in medically underserved communities would encourage innovative education and training programs, and increase the supply of health care providers. Current state-level efforts to dictate the training and curricula for community health workers are likely to move us in the wrong direction and should be evaluated in terms of the impact on access to care.[53] The attributes that make these individuals helpful in improving health outcomes in underserved communities may be lost with standardization in required education or training.

For example, some clinic-based programs recruit community health workers from among their patients who, despite their lack of formal training, have much to contribute. *Health* is the goal, not health *care*. Community health workers and others can contribute by monitoring individuals with chronic conditions and making sure they have access to medication before they end up in the hospital.

**Encourage Alternatives to Traditional Providers.** Traditional providers cannot afford to practice in rural or poor communities. The use of alternative providers should be encouraged, and regulations that constrain alternative methods of providing care should be lifted in medically underserved areas. For example, mobile health clinics, such Chicago's Asthma Vans, focus on a particular service and bring it to consumers. The critical component in getting the best care is to give consumers some choice.

If providers who serve individuals in medically underserved areas were exempted from some state laws and regulations, patients would have more options and be more likely to get the care they need. This could prevent many unnecessary visits to the emergency room. Moreover, the type of lifestyle changes that community health clinics encourage are likely to have a much bigger effect on health in underserved communities than a brand new critical care hospital.

**Expand Retail Clinics.**[54, 55] Walk-in clinics are small health care centers located inside big-box retailers, pharmacies or strip shopping center storefronts. The consulting firm Deloitte estimates there are 1,100 to 1,200 retail clinics currently, and the number is likely to grow to 3,200 by 2014. Prices are often only half that of traditional medical practices. The clinics are staffed by nurse practitioners and offer a limited scope of services. Services are reimbursed by most health plans, but about one-third of patient visits are paid out-of-pocket. Many of these cash-paying patients are uninsured.

State officials and local zoning authorities must license a facility, but some local representatives are opposed to retail clinics, making growth difficult.[56] For example, Massachusetts health officials were opposed to plans to open MinuteClinics in the Boston area and actively tried to prevent the clinics from opening.[57] In an interview, the Director of Communications for the Boston Public Health Commission reported that the organization's board was exploring ways to limit the presence of retail clinics and whether the city has authority to do so. The official called the clinics "unsafe" and "ill-equipped to monitor community health needs."[58]

Retail clinics also often have a hard time meeting licensing requirements, because some states require amenities that make it cost prohibitive to operate a retail clinic. In Massachusetts, regulations for clinics require a separate entrance for patients, handwashing stations in patient bathrooms, minimum size requirements for exam rooms, an area for storing dirty linens and a separate reception desk.[59] In addition, clinics must have blood collection facilities even though MinuteClinics do not treat conditions requiring blood tests.[60]

**Health Stamps.** Medicaid recipients should be given funds to cover the cost of preventative care and allowed to choose where they want to buy services. Like food stamps, funds could be accessed through a health debit card. What they do not spend on preventative care could be applied to the purchase of other health care services, giving recipients an incentive to shop around for care. Consumer shopping would create incentives for facilities to experiment with forms of delivery, locations and hours. Medicaid patients should be allowed and encouraged to purchase care from for-profit entities, so that entrepreneurs have an incentive to invest in innovative methods of service.[61] This might lead to greater use of for-profit innovations such as retail clinics.

**For-Profit Hospitals.** In Southern California, Prem Reddy has taken stage as an innovative health care entrepreneur.[62] In hospitals he has taken over, he has eliminated some expensive services.[63] He has changed how health personnel are employed, taken steps to assure patients are discharged as soon as it is medically appropriate and reconfigured systems to make services more convenient. His efforts have kept hospitals open, improving access to care in the communities where they are located. Critics lament the focus on profit-generating services, but forcing hospitals to provide every service makes hospital care expensive.[64]

**Alternative Reimbursement Codes.** State Medicare and Medicaid providers who serve low-income populations should be allowed to use direct reimbursement codes that differ from those mandated by the U.S. Department of Health and Human Services.

At one time, states had the authority to design codes for their own use for Medicaid reimbursement. Alaska, for example, created reimbursement codes for behavioral health paraprofessionals who served rural populations. When the state codes were abolished in 2003, Alaska was allowed, on a test basis, to use a private coding system provided by ABC Coding Solutions. The state saved several million dollars, but was required to sunset the codes in favor of codes approved by the Department of Health and Human Services in January 2010.[65]

**Equivalent Reimbursement for Comparable Services.** Providers should be reimbursed based on the skill required to perform the service, rather than who performs it. This would encourage more efficient use of personnel.[66]

Restrictions on reimbursement to pharmacists for disease management in nonorganized systems and pharmacies reduce the incentives for, and availability of, pharmacists to provide these services. If the objective is to encourage innovations in the provision of care to underserved areas and populations, reimbursement must be more flexible and able to accommodate new ways of structuring and providing care. The beneficial side effect is that researchers will have data on exactly who is providing care and can evaluate the outcomes.

**Three-Year Medical Degrees.**[67] A number of medical schools are implementing three-year degree programs as an alternative to the traditional four-year program. A study from the Carnegie Foundation for the Advancement of Teaching recommends that all medical schools consider adding a three-year degree option.[68] Such programs could significantly reduce the cost of a medical education to students and medical schools, and would allow an increase in the number of doctors sooner rather than later.

## Conclusion

If innovators were not constrained by regulations and reimbursement mechanisms that favor traditional means to deliver care, the availability of health care would increase and competition would lower prices.

## Policy Recommendations

The key to expanding access to care is to free medically-underserved populations — those in rural areas or in poor urban communities — from regulations that limit access to care. The kind of policies that should be considered include:

- ⇨ End many state licensing and scope-of-practice restraints.
- ⇨ Allow nonphysician clinicians to perform more duties without physician supervision.
- ⇨ Promote innovation in medical education, including three-year medical degrees.
- ⇨ Relax education and training requirements for professionals working with underserved populations.
- ⇨ Allow alternative reimbursement codes to include non-physician clinicians.
- ⇨ Reform the tax code so it does not favor nonprofit hospitals over private entities.
- ⇨ Expand alternatives to traditional providers, such as retail clinics.
- ⇨ Reform local zoning and licensing laws to allow retail clinics to offer a wider range of services.

By exempting providers who serve individuals in medically underserved areas from many state laws and regulations, patients would have more options and be more likely to get the care they need.

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