

National trends of physician assistant workforce: 1980 to 2007 U.S. Surveys

Running head: physician assistant workforce, U.S. trends

Xiaoxing Z. He, MD, MPH¹, Ellen J. Cyran, MS², Mark J. Salling, PhD²

1. Xiaoxing Z. He is affiliated with the Department of Health Sciences, Cleveland State University, 2121 Euclid Avenue HS 122, Cleveland, OH 44115. Email: x.he69@csuohio.edu

2. Ellen J. Cyran & Mark J. Salling are affiliated with Northern Ohio Data & Information Service, Cleveland State University, 1717 Euclid Avenue, Cleveland, OH 44115. Emails: e.cyran@csuohio.edu, m.salling@csuohio.edu

Corresponding author: Dr. Xiaoxing Zing He, Phone: 267-687-5447, Fax: 267-687-9316, E-mail: xiaoxing.he@jhsph.edu

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ABSTRACT

Background: The physician assistant (PA) profession is a signature US-style medical workforce. However, relatively little is known regarding national trends of the PA workforce.

Methods: We examined the 1980-2007 U.S. Census data to determine the demographic distribution of the PA workforce and PA-to-population relationships. Maps were developed to provide graphical display of the data. All analyses were adjusted for the complex census design and analytical weights provided by the Census Bureau.

Results: In 1980 there were about 29,120 PAs, 64% of which were males. By contrast, in 2007 there were approximate 97,721 PAs with more than 66% of females. In 1980, Nevada had the highest estimated rates of 40 PAs per 100,000 persons, and North Dakota had the lowest rates (three). The corresponding rates in 2007 were about 85 in New Hampshire, and ten in Mississippi. The levels of PA education have increased from less than 21% of PAs with four or more years of college in 1980, to more than 65% in 2007. While less than 17% of PAs were minority (Non-White) in 1980, this figure rose to 23% in 2007. Although nearly 70% of PAs were younger than 35 years old in 1980, this percentage fell to 38% in 2007.

Conclusions: The trends of sustained increase and geographic variation in the PA workforce were identified. Educational level, percentage of minority, and age of the PA workforce have increased over time. Major causes of the changes in the PA workforce include educational factors and federal legislative or state regulatory.

Background

The physician assistant (PA) profession emerged in the late 1960s, and has continued to thrive, becoming a signature US-style medical workforce with international popularity.¹⁻³ The sustained growth of the PA workforce is supported by federal Title VII of the U.S. Public Health Service Act, in response to skyrocketing medical expenditures, the physician shortage, and the primary care shortage crisis.⁴⁻⁹

The physician shortage and the aging population, makes cost containment a critical issue.¹⁰⁻¹² A cost-effective way to meet the aging population's primary care needs is the PA model.^{13, 14} As the growth of the PA profession, it is important to understand the trends of changes in the PA workforce, in order to promote health education and disease prevention for improving the population's health.¹⁵⁻¹⁹ Furthermore, evidence from public health system research indicates that the population's health is inevitably influenced by national policies and optimal supply of medical workforce.²⁰ However, there is not much literature regarding the current supply of the PA profession. While Larson et al. attempted to describe the status of the PA workforce; the limitations are lack of current data and population information.²¹

Using nationally-representative population data for 1980, 1990, 2000, 2005, and 2007, we examined the overall trends of changes in the PA workforce. As part of this analysis, we also examined the demographic characteristics and socioeconomic dimensions of the PA workforce, and PA-to-population relationships nationwide.

METHODS

Sources of Data

The sources of data are the 1980, 1990, and 2000 U.S. decennial Census and the 2005 and 2007 American Community Survey (ACS). For this analysis, the Integrated Public Use Microdata Sample (IPUMS) is used. The IPUMS data is the Public Use Microdata Sample (PUMS), released by the U.S. Census Bureau and enhanced for longitudinal research.²² The IPUMS draws its sample in all 3,141 counties (or county equivalents) in the U.S.²²⁻²⁵ The IPUMS data for the 1980, 1990, and 2000 are from the “long form” samples of the U.S. decennial Census in those years. The IPUMS data for the 2005 and 2007 are from the annual ACS. The ACS is a rolling sample through the year and is adjusted to the Census Bureau’s independent population estimates program.²² The ACS protocol calls for a sequential contact with a mixed-mode survey, resulted in a high (over 95%) response rate.²² With the use of IPUMS data, the differences in the surveys’ definitions of occupations over time are resolved.

Study Variables

In all of the IPUMS data since 1980, respondents were asked to report their job activity and occupation.²³ Participants reported whether they worked at a private-for-profit; private not-for-profit; local, state, or federal government; were self-employed; or worked without pay in farm and family business. Participants also described the industry in which they worked, and responded to a variety of other employment questions, including their occupation. Thus, we are able to analyze the characteristics of such occupations as physician, PA, and personnel manager. We analyzed these study variables with a focus on the PA profession to describe the trends of the PA workforce. This is the first step of a serial analysis (forthcoming) to examine the changes in healthcare workforce structure in order to identify the impact on health services utilization or medical expenditures, and to project the optimal supply of the nation’s medical workforce.

ANALYSIS

We applied the Geographical Information System (GIS) analysis to examine the patterns of changes in the PA workforce from 1980 to 2007. Maps were developed to provide an intuitive graphical display of the data. The analysis documented how demographic trends and the geographic distribution of the PA workforce have changed over time, with a focus on the most recent period from 2000 to 2007. In addition to analyzing overall trends, we assessed the degree of variation in the PA workforce distribution across the states. Furthermore, we examined the ratio of PAs to population by state. The analysis was supplemented with the Occupational Employment Statistics (OES) from U.S. Department of Labor regarding the PA profession's average hourly and annual wages. All analyses were adjusted for the complex census design and analytical weights provided by the Census Bureau.

RESULTS

Overall Trends of the PA workforce

The estimated number of PAs more than tripled from 1980 to 2007. In 1980, there were about 29,120 PAs, nearly 64 percent of which were male. By 2007, approximately 97,721 PAs were identified with more than 66 percent being female (Table 1). From 1980 to 1990, there was a decrease in the number of PAs. Although there was only a slight increase in male PAs, female PAs had been more than tripled from 1990 to 2000. In the five-year period between 2000 and 2005, there was an increase of more than 10,000 PAs among both males and females. In the following two years of 2005 to 2007, there was a relatively small increase in male PAs (1,259), but sustained growth in female PAs (14,327).

Demographic Characteristics of the PA workforce

The educational background of PAs has improved from less than 21 percent of PAs with four or more years of college in 1980, to more than 65 percent in 2007. In 1980, nearly five percent of the PAs had less than a twelfth grade education. By 2007, only 1 percent of the PAs had an education background of less than twelfth grade. The increase in educational attainment in the PA profession is especially notable for females (Table 1). In 1980, about 5 percent of female PAs had four or more years of college. Dramatically, over 40 percent of female PAs had four or more years of college by 2007.

In terms of racial and ethnic profile, while fewer than 17 percent of PAs were minority races (non-White) in 1980, the estimated percentage of PAs that were minorities increased to 23 percent by 2007 (Table 2). Asian American PAs had the greatest percentage increase over time. Between 1980 and 2007, Asian American PAs increased threefold – growing from two to six percent of all PAs.

The age profile of the PA workforce had also undergone significant change. While nearly 70 percent of PAs were less than 35 years old in 1980, this estimated percentage fell to 38 percent in 2007 (Table 2). The most remarkable changes occurred among the 45 to 54 age cohort. In 1980, this age group composed of only seven percent of the PA workforce; by 2007, more than 20 percent were 45 to 54 years old. Other noticeable changes were among the 35 to 44 and 55 to 64 years old cohorts. In 1980, an estimated 17 percent of the PAs were 35 to 44 years old. By 2007 the estimated percentage had increased to about 30 percent - nearly doubling its share of the PA workforce in 27 years. While only three percent of the PAs were 55 to 64 years old in 1980, almost 10 percent of all PAs were estimated to be in that age group by 2007.

PA-to-Population Ratios and Wages

Ratios of PAs per 100,000 persons varied greatly among the states for all years in the study (Table 3). In 1980, Nevada had the highest estimated ratios - 40 PAs per 100,000 persons, followed by Florida (29.8), and Alabama (26.2). North Dakota had the lowest ratios - three PAs per 100,000 persons. Other states with low ratios in 1980 include Vermont (3.9), and Wyoming (4.3). In 2007, the highest ratios of PAs per 100,000 persons were 84.7 in New Hampshire, 75.3 in Maine, and 63.0 in Rhode Island. The three states with the lowest ratios were Mississippi (10.4), New Mexico (11.4), and Missouri (11.7).

Data on salaries in 2007 showed that Connecticut's PAs earned the highest hourly mean wages (\$43.8) and annual mean wages (\$91,010). The lowest hourly mean wages were \$20.3 in Mississippi, and it also had the lowest annual mean wages at \$42,160 (Table 3).

Geographic Shifts in the PA Workforce

In 1980, the top-five states with the highest estimated number of PAs were California (3,120), Florida (2,520), New York (1,920), Illinois (1,800), and Texas (1,740). Conversely, the five states with the lowest estimated number of PAs were North Dakota (20), Vermont (20), Wyoming (20), New Hampshire (40), and Alaska (40). The geographic distribution of the PA workforce has been changing over time. By 2007, New York employed the greatest estimated number of PAs (9,010), closely followed by California (9004), Texas (6646), Pennsylvania (5874), and Florida (5806). North Dakota remained as the one state with the lowest number of PAs (106) employed in 2007. Two other states that employed fewer than 200 PAs in 2007 were South Dakota (170) and Montana (199) (data not shown).

Figure 1 and 2 displayed the absolute changes and the percentage changes in the rate of PAs per 100,000 persons across the states. The ratios of PAs to population had increased since 1980 in all but three states - Missouri, Nevada, and New Mexico. The greatest growth was in New England and upper Midwest states. Maine, New Hampshire, and Iowa had the greatest positive changes in the rates of PAs per 100,000 persons (Figure 1). The states with the largest percentage increase in the rate of PAs to population were Main, Vermont, New Hampshire, North Dakota, and Wyoming (Figure 2).

Discussions

Our study describes the trends of the PA workforce between 1980 and 2007, based on estimates from the U.S. Census Bureau. A major trend is the increase in PA workers, with the greatest expansion of PA workforce between 2000 and 2005. In addition, levels of education, percentage of minority, and age of the PA workforce have increased. One notable change in PA workforce is the ratios of males to females, from about 1.7 in 1980 down to 0.5 by 2007. Another remarkable change is that the rates of PAs to population and the average wages of PAs vary greatly across the 50 states and District of Columbia. Furthermore, there is a growing concentration of the PA profession in New England and upper Midwest states over the 27 years of study period.

The greatest expansion of PA workforce in 2000 to 2005 likely resulted from the third period of the federal Title VII Public Health Service Act which support for training of health professions in medicine and dentistry.⁴⁻⁶ The first period, from 1963 to 1975, led to the emergence of the PA profession. Title VII support in the second period, from 1976 to 1991, marked the establishment of primary care disciplines and related divisions in all medical school.⁶

Meanwhile, there was a small decrease in male PAs and a slight increase in female PAs, as shown in our findings. In the third era, from 1992 to present, national policy goals have been emphasized on caring for vulnerable populations, greater diversity in the health professions, and innovative curriculum to prepare trainees.⁶ Apparently, the third period of Title VII support induced a sustained growth of PA workforce, especially the expansion between 2000 and 2005. Our findings of increased percentage of minority PAs and levels of PA education could serve as direct evidence of the targeted outcomes of the Title VII third era's national policy goals.

While we see favorable increases in the total number of PAs, the levels of education, and the percentage of minority PAs, an alarming sign is also indicated in our study. Although it is still a relatively young medical workforce, the PA profession is growing older - a reflection of other professions and the nation's population. To keep up with the PA profession's original goals of meeting the aging population's primary care needs, it is imperative to develop innovative recruitment strategies for PA programs to enroll new PA students in their 20s and early 30s. This is critically important in building a sustained supply of the PA workforce.

Recruiting younger PA students might also help to balance the ratios of males to females, since "federalization of PA profession" appears to be the consequences of more education, observed in females, and that females cooperate better with physician regardless of their age.²⁶ In addition, previous study suggests that younger PA students are more likely to stay and practice in rural areas, if they are recruited and receive training there²⁷. Therefore, recruiting younger PA students locally would help to meet the original Title VII goals of filling the existing gap of the physician shortage and enhancing the primary care practice in rural or underserved areas.

Our findings have shown a large variation among the 50 states and District of Columbia with regard to the rates of PAs per 100,000 persons and the PAs' average wages. Some possible

explanations include the differences or changes over time in state laws for PA practice regulations, the delegation of services agreements (DSA), and the numbers of PA educational programs. A comparative readings of summary clauses of state regulations indicate that a favorable practice environment, in particular the flexibility of physician supervision requirements,²⁸ appears to be the most important factor in encouraging the growth of the PA workforce. For example, New Hampshire, Maine, and Rhode Island - the three states with the highest rates of PAs per 100,000 persons in 2007, had relatively flexible supervision requirements. In these three states, a physician was not required to be physically present, while easy and effective electronic or telecommunications were applied.

However, more restricted supervision requirements existed for the three states with the lowest rates of PAs per 100,000 persons in 2007. Mississippi requires on-site presence of a physician for the first 120 days of care, and a supervising physician must review and initial 10 percent of PA-written charts monthly. New Mexico demands immediate communication between physician and PA to specify what services may be provided. Missouri mandates that the attending physician must practice in the same facility as the PA, and be present at least 66 percent of the time when a PA is providing care.

Furthermore, the enacted dates that PAs were licensed, registered, or certified to practice had inevitable impact on the variations of PAs' ratios per 100,000 persons and PAs' average wages. In 2000, Mississippi - the state with the lowest rate of PAs per 100,000 persons and the lowest average wages in 2007 - was the last state to establish the statute for PA practice.²⁸ Our study suggests the necessity for the federal government to standardize PA practice regulations across the nation in order to effectively allocate workforce, improve quality of care, and reduce health disparities.

Moreover, we posit that the availability or the numbers of PA educational programs played a chief role on influencing the geographic distribution of the PA workforce. Based on a list of all accredited PA educational programs by the American Academy of Physician Assistants (AAPA),²⁹ in three states with the lowest rates of PAs per 100,000 persons in 1980, two states – Vermont and Wyoming did not have any PA educational programs. Similarly, no PA educational programs were found for two of the three states in 2007 with the lowest ratios of PAs to population - Mississippi and Missouri. Therefore, a national approach or coordinated strategy for training and retaining PAs is recommended in order to sustain the PA workforce supply and balance the distribution of the PA workforce more equitably.

Limitations associated with the data should be noted. Like all surveys, U.S. Census surveys are subject to potential problems of sampling error and response bias. The PA samples are relatively small for some states in 1980. Data on their attributes at the national level are more reliable and the relatively high response rates minimize the potential for selection bias. In addition, the measures of occupation and job activities were self-reported, and might contribute to reporting bias. We included only the employed PAs in this analysis, thus minimized the potential reporting bias. Finally, the estimated numbers of employed PAs appear to be higher than those estimates of clinically active PAs in the AAPA survey report. The different assumptions or survey sampling methods and questionnaires used for data collection attribute to the differences in the estimates. Among the study strengths are innovative analysis idea and unique research design to explore a topic without much existing literature.

Conclusions:

As a first step in identifying the optimal structure of the nation's medical workforce, our study informs U.S. policy by providing new information about national trends in the PA

workforce from 1980 to 2007. Further studies are necessary to inform the development of national policies with regard to cost-effectiveness of various supply patterns for meeting primary care needs, especially in rural or underserved areas, and the impact of various supply patterns on medical expenditures in the nation's health care system.

Competing interests:

I declare that I have no competing interests.

Authors' contributions:

X. Z. He conceived and designed the study, interpreted the preliminary results, and was responsible for writing the paper. E. J. Cyran completed preliminary analyses. M. J. Salling made geographic maps and helped to edit the draft. J. J. Bazyk assisted with the study and analyses. All authors read and approved the final manuscript.

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Figure 1: Change in the Rate of PAs per 100,000 Persons, 1980-2007

Change in Physician's Assistants per 100,000 Persons 1980 to 2007

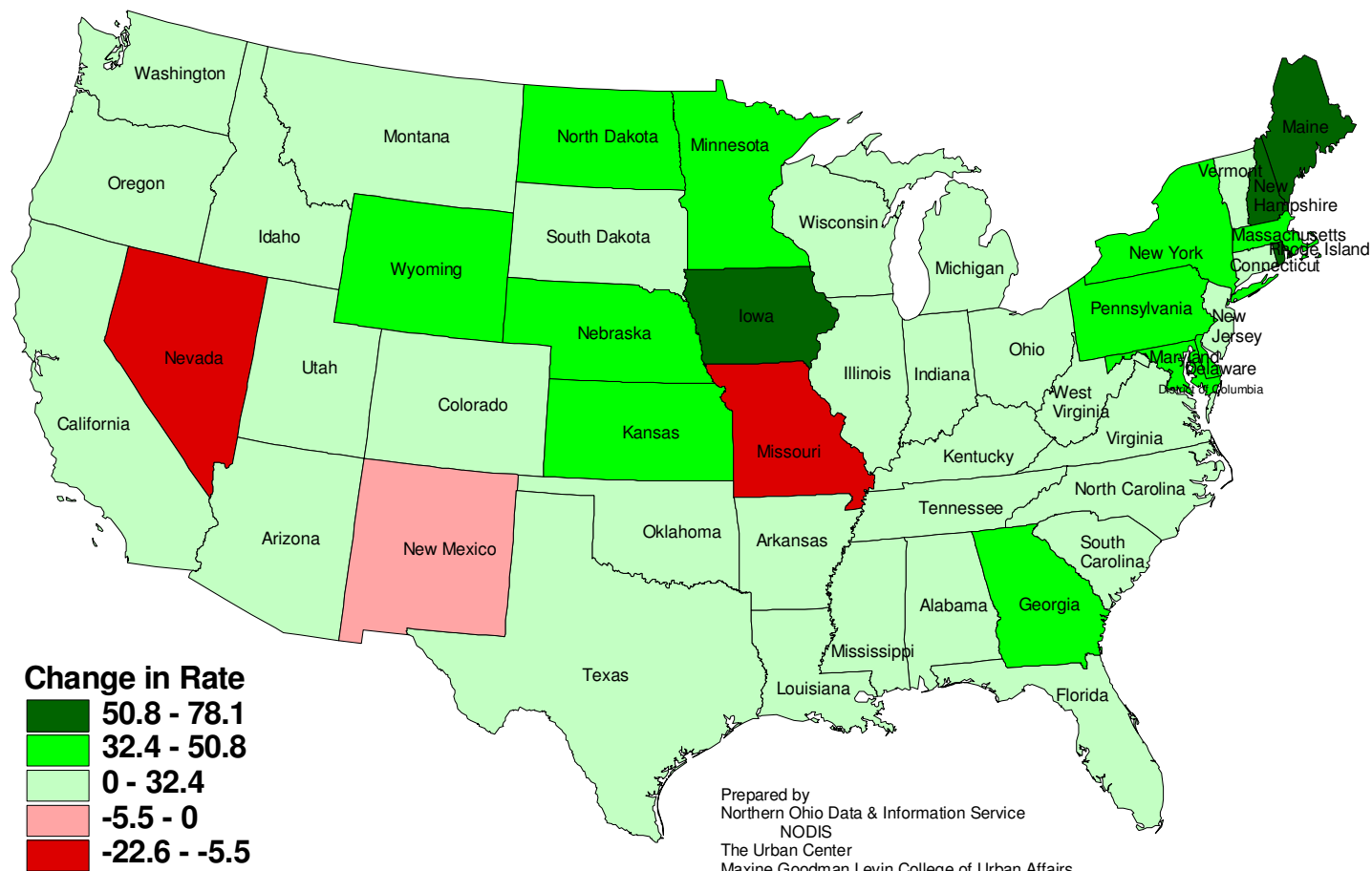
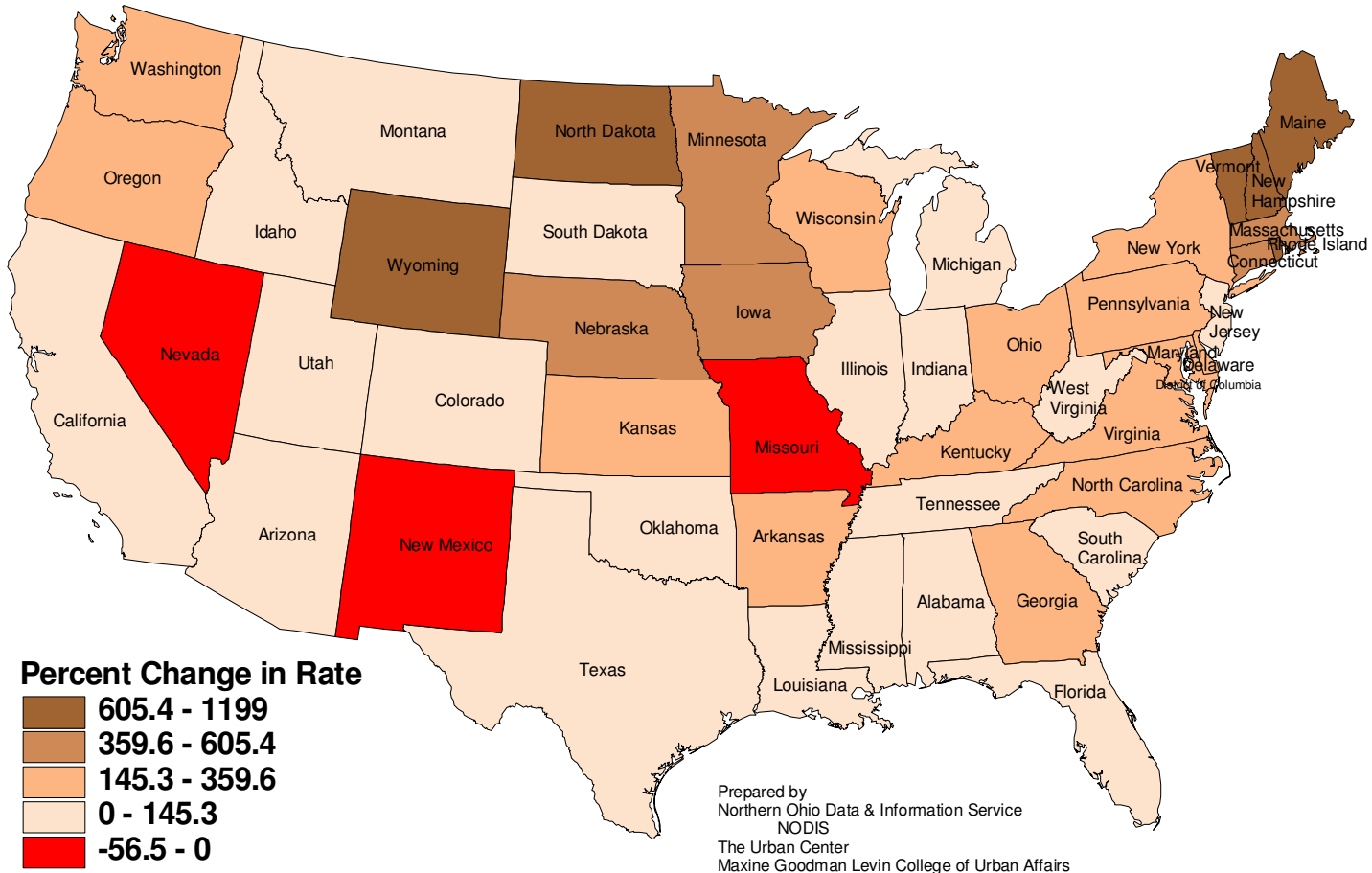


Figure 2: Percent Change in the Rate of PAs per 100,000 Persons, 1980-2007

Percent Change in Physician's Assistants per 100,000 Persons 1980 to 2007



Additional files provided with this submission:

Additional file 1: tables_hrh.doc, 177K

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