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Dear Maryland Policy Makers:

The Maryland Health Care Commission (MHCC), the Governor's Work Force Investment Board (GWIB), and the Governor's Office of Health Care Reform are pleased to release two studies that examine Maryland's health care work force, which may be found at http://mhcc.dhmh.maryland.gov/workforce/Pages/Health_Workforce_Study.aspx. Funding for the two reports was provided through a grant from the State Health Reform Assistance Network at the Robert Wood Johnson Foundation. IHS Global Inc. (IHS) researchers conducted the work under a contract with RWJF.

The first report examines the capabilities of current health occupation licensure/relicensure data systems for use in estimating future health care work force needs in the state. IHS researchers identified considerable variability in existing data systems. Almost all boards now collect information on race and ethnicity, but details on the location, type of practice, and characteristics of the practice are not consistently collected. The Maryland Board of Physicians' data system was flagged as containing most information necessary to estimate future work force needs. IHS found that other health care occupations licensure/relincensure systems lacked important data elements needed to model the future health care workforce.

The second study estimates the adequacy of primary care and mental health services using a statistical model that takes into account the existing work force (supply) and population characteristics, insurance coverage status, and health risk factors (demand) that drive the use of health care services. The Health Services and Resources Administration (HRSA) has begun to examine demand modeling approaches similar to the one used by IHS for identifying provider deficits and for designating health provider shortage areas (HPSAs). These approaches could improve Maryland's ability to qualify for HPSA designations in the future. A demand model also allows for the explicit consideration of various initiatives, including insurance coverage expansions and delivery system reforms.

The supply estimates generated in the study are consistent with previous work. Maryland has roughly 4,560 full-time equivalent primary care physicians (general internists, family medicine physicians, pediatricians, and gerontologists). Using their demand model, IHS researchers estimate Maryland needs roughly 4,357 primary care physicians, leaving a small surplus of roughly 200 primary care physicians. There is variation in both supply and demand throughout the state, resulting in areas of deficit, particularly in local areas, despite the overall statewide surplus. Rural counties on the Eastern Shore and in Southern Maryland were estimated to have the greatest percentage deficits, and Prince George's County had a large absolute deficit of over

160 primary care physicians. The study recognized that physician assistants (PAs) and nurse practitioners (NPs) could offset some of the primary care physician deficit, but data limitations highlighted in the first study prevented the IHS researchers from precisely estimating the offsets to the primary care physician deficit that could be made up by PAs and NPs. Limited participation in MCO networks, the concentration of practices in higher income communities, and other such factors could mean that vulnerable populations have sub-optimal access to care, even in jurisdictions that had an adequate numbers of primary care providers overall.

An analysis on the adequacy of the mental health work force yielded mixed results. Most Maryland jurisdictions were judged to have an adequate absolute supply of psychiatrists. Surprisingly, the absolute number of psychologists was below estimated demand. The report noted that clinical social workers, licensed nurse psychotherapists, and marriage and family counselors might reduce some of the psychologist deficit, but data limitations prevented IHS researchers from estimating the precise offset. The study warns that mental health professionals' unwillingness to participate in insurance carriers' networks means that the actual supply of mental health providers available to consumers is much lower than the absolute supply level.

The second report represents an important methodological improvement in estimating workforce needs. Previous studies of Maryland's health care workforce focused exclusively on the physician workforce supply and benchmarked Maryland's supply against national supply levels. That approach implicitly assumed disease burden in Maryland corresponded to the national average. Those studies found Maryland had a greater supply of physicians per 10,000 than the US. Using the national 2000 benchmark, Maryland's primary care physician supply was judged 11% higher than the national average. The new approach attempts to explicitly account for the underlying health of the population. As a consequence, Maryland's primary care physician surplus virtually disappears, falling to roughly 5% above forecasted demand. More significantly, fourteen of Maryland's twenty-four jurisdictions have deficits of primary care physicians, up from three jurisdictions in the old methodology. Although IHS was not able to explicitly assess the contributions of nurse practitioners and physician assistants, the framework for such estimates has been put in place.

The MHCC, GWIB, and GOHCR are releasing the report to stakeholders for comment and suggestions on further refinement of the projections. Improving data systems at the health occupations boards will be the next priority so that the complete health care workforce may be considered. Further refinements in the demand equations and more detailed microdata below the county level would enhance the precision of the estimates. In collaboration with the health occupation Boards and with funding support from GWIB, the study will move to its third phase in the coming months to enhance existing data systems.

If you have further questions, please contact Srinivas Sridhara at 410-764-8789.

Sincerely,

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