A pending influx of newly insured Americans, rapid growth in the older population cohort, and a growing incidence of chronic disease have raised concerns among stakeholders and observers about the adequacy of the nation’s primary care infrastructure. Some have called for measures to increase the number of physicians in primary care practice; responses have included several new medical schools opening their doors in recent years, incentives to encourage residents to choose primary care, and augmented primary care funding mechanisms under the Patient Protection and Affordable Care Act of 2010 (ACA). Others (and the voices overlap, to some extent) call for expanding the role of other clinical professionals, such as nurse practitioners (NPs) and physician assistants (PAs), through changes in scope of practice laws and reimbursement. Here too action has ensued. American Medical News reports that over 400 scope of practice bills were introduced in state legislatures in 2012. Although it must be noted that most of these failed to pass, Nevada made significant changes and Virginia nurse practitioners and physicians shepherded a compromise measure through their legislature. Bills are still pending in other states.

The National Governors Association at the end of 2012 published a paper titled “The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care.” This publication offered states an analysis of the demand, a review of the literature on NP performance, and a survey of current state regulation. It concluded with a suggestion that states “might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care.” The University of Virginia-based State Health Care Cost Containment
Commission, formed to advise governors, their cabinet members, and state legislators on health care cost-containment strategies, has scope of practice expansion for NPs and PAs on its agenda as well.

At the present time, NPs in many states are limited in their practice by regulation. A majority of states require some degree of physician supervision of NPs, often with rules for how collaboration and adherence to protocols must be documented. NPs who practice in more than one location may be required to execute multiple collaboration agreements. Seventeen states and the District of Columbia allow independent practice. Variation occurs across states with respect to NPs’ ability to order tests, refer to other clinicians or sites of care, and prescribe drugs. Because PAs practice by definition under physician supervision, independent practice has not been much of an issue. Once they have obtained state licensure, PAs are able to carry out a range of tasks that are a function of physician delegation rather than state law. Even here there are tensions, however, with PAs as well as NPs engaged in some contention as to what exactly constitutes supervision in an electronic age. Particularly in the case of rural areas, the idea that an NP or PA cannot work if a physician is not physically present seems impractical at best.

Reimbursement and also coverage rules represent barriers to expanded practice. Some payers, both public and private, do not recognize NPs as primary care providers with the right to bill for services. Two Colorado health plans recently drew publicity because they refused to pay for care of their members by NPs in an urban (that is, not underserved) area, regardless of patient preference or comparable cost. NP services are often provided as “incident to” physician services, which must occur under on-site supervision and which are billable at the physician rate. NPs are prohibited under Medicare from ordering home health services or durable medical equipment for a patient.

Proponents of expanding NPs’ scope and authority point to research indicating that NPs provide a level of care quality comparable to that of physicians and indeed may generate higher patient satisfaction scores. Some suggest this may have to do with nursing’s educational model, which places greater emphasis on a holistic view of the patient and on empathy than the medical model tends to.

Graduating NPs are more likely to choose primary care than medical school graduates; Joanne Pohl and colleagues cite data indicating that primary care NPs accounted for 84 percent of all graduates in 2012, compared with about 11.6 percent for physicians. By contrast,
the American Academy of Physician Assistants reports that only about one-third of practicing PAs have remained in primary care.

NPs and PAs can be produced more quickly and cheaply than physicians. NPs typically earn a BSN and then a master’s degree. Julie Fairman and colleagues calculated that between 3 and 12 NPs could be trained for the price of training one physician. Similarly, most PAs have a bachelor’s degree and subsequently complete an accredited PA program that leads to a master’s degree.

It is precisely this difference in training that is the major theme in opposition to expanded practice, with many physicians insisting that only their deeper education and more rigorous clinical training assure the diagnostic skills and treatment experience necessary to safeguard patients. Some observers suggest that defense of turf and a trade guild mentality is often couched in the language of patient safety. Clearly, competition for what physicians view as their established authority and income plays a role in resisting practice expansion for others. (Interestingly, the NGA report cites research showing no variation in physician earnings between states that have expanded NP scope of practice and those that have not.7)

Expansion proponents hasten to emphasize that NPs are complements to, rather than substitutes for, physicians; seek only to practice to the legitimate extent of their knowledge and training; and know when to defer to a physician. Stipulating to this still leaves questions about the communications infrastructure and the relationships that need to be in place for appropriate consultation or handoff to occur. Attitudes can be difficult to shift. A survey by Karen Donelan and colleagues of physicians and NPs found considerable disagreement between the two groups on their respective roles in primary care and on the meaning of practicing to the full extent of one’s education and training.8

Some analysts sound notes of caution without taking sides. David Auerbach of RAND notes that it is unclear whether NPs will take the lead in the new models of care delivery and reimbursement envisioned in the ACA, and indeed whether their training will include the appropriate management skills.9 The Cochrane Collaboration, which conducts international systematic reviews of health care research, looked at nurses (not specifically NPs) substituting for doctors in primary care around the globe. Review authors found comparable quality, but were unable to conclude that physicians’ workload was reduced by delegating to nurses. They also noted that savings are not a given: “Even though using nurses may save salary costs, nurses may order more tests and use other services which may decrease the cost savings.”10
Reconfiguring primary care may not have to be a matter of taking sides. It may be that a more collegial climate is developing, particularly among those clinicians who have experienced interprofessional training. Expansion proponents, opponents, and observers have been able to agree on the value to all clinical professionals of practicing as part of a team. Still unresolved is what optimal team composition, leadership, and communications might be. Given the many changes under way in the health care system, teamwork will probably evolve on the ground, both in practice settings and virtually. The extent to which all professionals feel able to use their knowledge and skills productively will surely have a bearing on success.

SESSION

Esther Krofah, MPP, program director in the Health Division of the National Governors Association’s (NGA) Center for Best Practices, talked about the NGA report on the role of NPs, forthcoming work on other nonphysician clinicians, and the status of state laws affecting their practice. Joanne M. Pohl, PhD, discussed her work on the role of NPs in meeting the nation’s need for primary care services. Andrew Bazemore, MD, MPH, reflected on how primary care practice is changing and patients’ expectations about how care is delivered. James F. Cawley, MPH, represented a PA perspective, including attention to their education, practice choices, and evolving aspirations.

KEY QUESTIONS

• What forces are driving the evolution of primary care, and in what directions?

• How can researchers and policymakers arrive at an understanding of what the ideal health care workforce should look like?

• What progress is being made toward making team-based care the norm? Is a campaign for independent practice on the part of NPs working in the opposite direction? Or, given the variation in care needs, is there sufficient demand for episodic care of the generally healthy that could be satisfied by independent practitioners while more comprehensive care and management is handled by a team?

• Is there evidence that expanded practice for NPs and PAs would ameliorate the geographic maldistribution of health care services in the United States?

• Are there ways to define or standardize which patient care tasks require physician involvement and which may be delegated?
ENDNOTES


