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**Over Extended: The Role of the Independent Nurse
Practitioner Practice in Addressing Problems with
Affordability of U.S. Primary Care**

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I. INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).¹ The Act contains many provisions intended to increase access to quality, affordable health care. With new regulations on pre-existing medical conditions, employer-provided medical benefits, and the expansion of Medicaid eligibility, it has been estimated that PPACA will effectively expand the provision of health insurance to an additional thirty-two million Americans by 2019.² It is difficult to argue with the altruistic intentions of the Act. Uninsured people are far more likely to forego necessary medical treatment because they simply cannot afford it.³ What remains unclear, however, is how this new influx of potential patients will be funded.

The United States already spends more, per capita, on health care than any other country in the world.⁴ Year after year, healthcare costs continue to increase at a rate far surpassing that of growth in national income.⁵ In 2008, U.S. healthcare expenditures

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1. Pub. L. No. 111-148, § 1201, 124 Stat. 119 (2010).

2. John Geyman, *Will Health Care Reform 2010 Improve Access And Quality of Cancer Care?* PHYSICIANS NAT'L HEALTH PROGRAM OFFICIAL BLOG (Aug. 8, 2010), <http://pnhp.org/blog/2010/08/08/will-health-care-reform-2010-improve-access-and-quality-of-cancer-care/>.

3. HEALTH, UNITED STATES, 2009: WITH SPECIAL FEATURE ON MEDICAL TECHNOLOGY 69, (2010), [http://www.cdc.gov/nchs/data/09.pdf#080](http://www.cdc.gov/nchs/data/hus/09.pdf#080).

4. *Health Care Spending in the United States and OECD Countries*, KAISER FAMILY FOUNDATION (Jan. 2007), <http://www.kff.org/insurance/snapshot/chcm010307oth.cfm>.

5. *U.S. Health Care Costs*, KAISEREDU.ORG (Mar. 2010), <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx#footnote1>.

reached \$2.3 trillion dollars, with physician and clinical services accounting for 21 percent of total costs.⁶ A significant portion of these dollars were spent on primary care services. Not surprisingly, in 2006, a little more than half of all physician office visits were made to a primary care physician (PCP).⁷ After all, “primary care deals with most health problems for most people most of the time.”⁸ Moreover, because PPACA emphasizes the importance of preventative care by making these services more affordable, the number of annual visits to PCPs can be expected to rise.⁹

Diminishing access to PCPs is adding to the skyrocketing cost of primary care services. Lack of access to primary care services has made emergency departments in local hospitals a main source of health care for an ever-growing number of Americans.¹⁰ A 2006 survey by the Centers for Disease Control and Prevention “strongly suggest[s] that the growing use of emergency departments is directly related to [a] shortage of [PCPs].”¹¹ Nationally, there are just 88 PCPs per 100,000 people.¹² So, for those in need of primary care services, the wait to see a doctor can be thirty days or more.¹³ The newly created Prevention and Public Health Fund will focus on increasing the number of PCPs.¹⁴ However, more doctors, alone, may not be the best answer to more affordable care.

At least one scholar has suggested that the key to bending the cost curve for the provision of primary care services in America will largely include an increased reliance on lower-cost providers of care.¹⁵ The nurse practitioner (NP) is one such provider.¹⁶ “A

6. *Id.*

7. *Ambulatory Care Use and Physician Visits*, CTNS. FOR DISEASE CONTROL & PREVENTION (Oct. 25 2010), <http://www.cdc.gov/nchs/fastats/docvisit.htm>.

8. Barbara Starfield, *The Primary Solution: Put doctors where they count*, BOS. REVIEW (Dec. 2005), <http://bostonreview.net/BR30.6/starfield.php>.

9. *Background: The Affordable Care Act's New Rules on Preventive Care*, HEALTHCARE.GOV (Jul. 14, 2010), <http://www.healthcare.gov/law/about/provisions/services/background.html>.

10. James Arvantes, *Emergency Room Visits Climb Amid Primary Care Shortages, Study Results Show*, AMERICAN ACADEMY OF FAMILY PHYSICIANS (Aug. 27, 2008), <http://www.aafp.org/online/en/home/publications/news/news-now/health-of-the-public/20080827er-visits.html>.

11. *Id.*

12. Ashley Halsey III, *Primary Care Doctor Shortage May Undermine Reform Efforts*, WASH. POST (Jun. 20, 2009), <http://www.washingtonpost.com/wp-dyn/content/article/2009/06/19/AR2009061903583.html>.

13. *Id.*

14. *Background: The Affordable Care Act's New Rules on Preventive Care*, *supra* note 9.

15. CLAYTON M. CHRISTENSEN ET AL., *THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE* 111-112 (McGraw Hill, 2009).

16. Unlike the Physician Assistant, or “PA,” who is required to work under the supervision of a licensed physician in all fifty states, NPs already have independent provider status in eleven U.S. states. It seems

[NP] is a registered nurse with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses.”¹⁷ The NP works either independently or as a member of a healthcare team.¹⁸

Despite the growing prevalence of NPs, there remains a common uneasiness among our population about the provision of medical care by non-physicians. Many feel that NPs lack the proper training to justify increased roles as independent providers of primary care services.¹⁹ This article will first provide a brief history of how doctors established themselves as the principal source of medical care for half a century, and the emergence of the NP as an important source of that care. Next, it will compare the NP’s education, scope of practice, cost-effectiveness, and clinical efficacy to the PCP standard. This article will then explore ways in which the cost of delivering primary care services can be reduced through more widespread prevalence of independent NP practices, stressing the need for continued professional collaboration, a redefined role for the PCP, increased access to care, and more efficient regulation. Finally, this article will provide recommendations for future regulation intended to further shape the provision of primary care services while maximizing the nation’s limited healthcare resources.

II. HISTORY OF PRIMARY CARE PHYSICIANS AND THE EMERGENCE OF NURSE PRACTITIONERS

a. The Physician and the American Medical Association

Before physicians enjoyed the level of professional deference bestowed upon them by society, the practice of medicine was viewed more as common-sense and less as the scientific-based study that is associated with healthcare today.²⁰ Throughout the 19th century, citizens were free to provide healthcare services to the sick, regardless of whether the provision of those services was preceded by any amount of formalized

more likely that the NP will be considered, at least initially, as a more realistic choice for the role of lower-cost provider due to the regulatory inertia created by their demonstrated ability in these eleven states.

17. CAROLYN BUPPERT, *NURSE PRACTITIONER’S BUSINESS PRACTICE AND LEGAL GUIDE 1* (1999).

18. *Id.*

19. Ginger Rough, *For Many, a nurse practitioner is The doctor*, ARIZ. REPUBLIC (Feb. 21, 2009), <http://www.azcentral.com/news/articles/2009/02/21/20090221nursepractitioners0220.html> (quoting Dr. Ted Epperly, then president of the American Academy of Family Physicians, “the [NP] replacing the family doctor is not good for America”).

20. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 17* (1982).

training.²¹ Even though the number of medical schools was increasing every year, little difference existed in the perceived expertise between those who received training and those who did not. This was due, at least in part, to the tremendous inconsistency in the quality of MD-granting institutions and the physicians that many fledging schools were producing.²²

In 1846, a small group of physicians met in New York City to discuss the topic of medical educational reform.²³ The group would later become the leading organization in the medical profession, the American Medical Association (AMA).²⁴ The organization's agenda was clear. The AMA hoped to standardize medical education in an effort to confer superior authority on all who completed training from an accredited institution.²⁵ However, fierce competition for patients within the physician community, itself, limited AMA members' desire to work together.²⁶ Thus, the organization could not realize the collective strength it would need to attain the profound level of influence it was seeking.²⁷

It was not until the late 19th century that competing physicians finally discovered something in which they could all believe: the need and importance of medical licensing.²⁸ Recognizing a strength in numbers, physicians from both well-respected medical schools and the less-respected commercial institutions teamed up to successfully lobby for statutes requiring medical licensing as a requisite to the legal practice of medicine.²⁹ However, establishing a statutory need for medical licensure was only half the battle. Because licensing requirements demanded little more than a medical diploma, without any ability to limit the number of institutions that could provide medical education, the amount of individuals who had access to the medical profession was virtually limitless.³⁰ As a result, the influence of the licensed physician, both

21. *Id.* at 47.

22. *Id.* at 116.

23. *Id.* at 90.

24. *Id.*

25. *Id.* at 91.

26. *See STARR, supra* note 20, at 92.

27. *See id.* at 93.

28. *Id.* at 102.

29. *Id.*

30. *Id.* at 116

professional and political, remained somewhat diluted.³¹

In 1910, the AMA teamed up with the Carnegie Foundation for the Advancement of Teaching, commissioning a young teacher named Abraham Flexner to individually assess every MD-granting institution in the country.³² The Flexner Report, as it would later be known, revealed that most institutions were increasingly unable to keep pace with the advancements in medicine, which were being made in the areas of science and technology.³³ Public pressure following the Flexner Report forced a major reduction in the number of medical schools, and prompted the formation of state medical school accreditation boards which universally accepted Flexner's (and the AMA's) way of rating medical schools as authoritative.³⁴ Armed with new, standardized medical degrees which legitimized their professional authority, increased solidarity within their ranks, and the grant of a monopoly to practice medicine from the states, the cultural influence of physicians skyrocketed.³⁵ Furthermore, as decreased access to medical education limited the supply of doctors, the concentration of power embodied within the AMA made the organization a powerful political force with which to be reckoned.³⁶ Unfortunately, society would soon realize that doctors could be expected to behave in the same way as all pragmatic people in a capitalistic environment who seek to maximize profit. In 1920, biostatistician Raymond Pearl first demonstrated that the distribution of doctors throughout the U.S. was closely related to per capita income, leading Pearl to remark about doctors, "they do business where business is good and avoid places where it is bad."³⁷

b. Emergence of the NP

The proliferation of the NP began in the 1960s, a decade that experienced shortages of physician-providers typical of the primary care profession today.³⁸ As physicians gravitated toward wealthier communities and higher-paying fields of specialization, the benefits of the NP's clinical and diagnostic abilities were considered particularly valuable

31. *Id.* at 102

32. STARR, *supra* note 20, at 118.

33. *Id.* at 120.

34. *Id.* at 120-21.

35. *Id.* at 15.

36. *See Id.*

37. *Id.* at 125.

38. BUPPERT, *supra* note 17, at 7.

in rural and underserved areas.³⁹ As the first NP educational programs began to pop up around the country, like physicians, NPs also lacked any standardized training program.⁴⁰ Following its creation in 1978, the National Council of State Boards of Nursing (NCSBN) defined the now-established minimum standard educational and licensure requirements for certification as a NP.⁴¹ As a result, regulators began passing laws to shape NP licensure and scope of practice.⁴² Despite any widespread ability to set up independent practice, and without a unified organization representing their interests, the number of NPs has steadily continued to increase to today's level of over 150,000 in the U.S. in 2009.⁴³

As could be expected, the AMA vehemently protected its sovereign control over the practice of medicine. Physicians, in the name of public safety, objected to an expanded role of the NP so long as it involved activities outside the supervision of a licensed doctor.⁴⁴ So, though NPs, in general, possess both medical diagnosis and prescriptive privileges throughout the country, doctors have been successful in muddying the regulatory waters and clouding public perception⁴⁵ As a result, the NP's scope of practice varies significantly from state to state.⁴⁶ At one extreme, the NP can practice autonomously within a pre-defined scope of treatment; at the other, NP activities must always be within the supervision of a doctor.⁴⁷ Between these two extremes lies the question: do the disparities in education and clinical effectiveness of the PCP and the NP actually warrant the fragmented regulatory environment that currently prevents the NP from effectively filling an important societal and healthcare need?

39. *Id.*

40. John Michael O'Brien, *How Nurse Practitioners Obtained Provider Status: A Lesson for Pharmacists*, 60 AM. J. HEALTH-SYS. PHARM. 2301-2307 (2003), available at MEDSCAPE (Dec. 17, 2003), http://www.medscape.com/viewarticle/464663_2.

41. *Id.*

42. BUPPERT, *supra* note 17, at 7.

43. Kaiser Family Found., *United States: Total Nurse Practitioners, 2009*, STATEHEALTHFACTS.ORG (Jan. 29, 2011), <http://www.statehealthfacts.org/profileind.jsp?ind=773&cat=8&rgn=1>.

44. O'Brien, *supra* note 40.

45. *See id.*

46. *Nurse Practitioner Scope of Practice*, AM. COLL. NURSING PRACTITIONERS, (Jan. 29, 2011) <http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465>.

47. *Id.*

III. A PROVIDER COMPARISON

a. Education

It should come as no surprise that physicians are among the most highly trained professionals. In addition to a four-year undergraduate degree, a PCP must obtain a four-year doctoral degree (M.D. or D.O.) and complete a three-year residency program.⁴⁸ The residency program is an opportunity for the inexperienced doctor to further hone medical judgment through continued hands-on, clinical training in the ambulatory, inpatient, and community setting.⁴⁹ Prior to being able to independently diagnose and treat patients, a PCP will have compiled over 15,000 hours of clinical experience.⁵⁰

Of course, this process is no guarantee that the doctor will be able to practice medicine, at least in a legal sense. A PCP must be licensed by a state medical board.⁵¹ In addition, licensed physicians are required to receive continuing medical education (CME); in some states, up to fifty hours of additional training per year are required.⁵²

The NP also possesses a four-year undergraduate degree which is typically followed by state licensing as a registered nurse.⁵³ Next, the prospective NP will generally obtain a Masters of Science in Nursing (MSN) degree, also required by most states.⁵⁴ Hands-on, clinical experience is also a part of the NP curriculum. An NP will log between 500-1500 hours of clinical experience before meeting the licensure requirements of most states.⁵⁵ Likewise, licensed NPs are also required to receive continuing medical education. On average, NPs need fifteen hours of CME every year.⁵⁶

Undergraduate studies being somewhat similar, an enormous disparity exists in the comparative cost between the education of PCPs and NPs. The total cost of tuition in 2009 to obtain a MSN for a NP specializing in family health averaged \$16,624 and

48. PRIMARY CARE COALITION: TEX. ACAD. FAMILY PHYSICIANS, COMPARE THE EDUCATION GAPS BETWEEN PRIMARY CARE PHYSICIANS AND NURSE PRACTITIONERS, <http://www.tafp.org/advocacy/resources/PCCIssueBriefScopeEdu.pdf> (last visited Feb. 27, 2011) [hereinafter COMPARE THE EDUCATION GAPS],

49. *Training Requirements - 2010*, AM. ACAD. FAMILY PHYSICIANS, <http://fmignet.aafp.org/online/fmig/index/family-medicine/training.html> (last visited Feb. 27, 2011).

50. COMPARE THE EDUCATION GAPS, *supra* note 48.

51. *Id.*

52. *State Medical Licensure Requirements and Statistics*, AM. MED. ASS'N 54 (2010), <http://www.ama-assn.org/ama1/pub/upload/mm/40/table16.pdf>.

53. COMPARE THE EDUCATION GAPS, *supra* note 48.

54. *Id.*

55. *Id.*

\$34,308 for resident and non-resident students attending public schools, respectively.⁵⁷ Standing in stark contrast to this figure is the annual tuition fees paid by a would-be PCP. According to a survey of average 2009 tuition costs of nearly all accredited medical schools, just one year of the MD program at a public medical school was \$3,610 more than the tuition cost of a complete MSN education at a public university.⁵⁸ The total price for a PCP education, therefore, can be well into the six-figure range.⁵⁹ Most notably, as the average newly-licensed PCP seeks his or her first real paying job, they will be over \$150,000 in educational debt which can take decades to pay off.⁶⁰

b. Scope of Practice

Today, the majority of NPs provide primary care.⁶¹ Nearly every medical dictionary, professional organization, and agency has attempted to define primary care. Although the many definitions vary to some degree, the words found most in common include “first-contact, continuous, comprehensive, and coordinated care.”⁶² Representing merely one level of healthcare, primary care is distinguished from secondary or tertiary care, which are commonly thought of as more consultative, shorter-term in nature, and available only as an option of last resort.⁶³ The PCP will consult with secondary and tertiary care providers to seek guidance regarding patients whose problems the PCP cannot definitively diagnose.⁶⁴ In fact, upwards of 85 percent of a given population will only require primary care services within a given year.⁶⁵ By implication then, the availability and efficient delivery of primary care services within any healthcare system is crucial.

At the apex of primary care services is the PCP. The PCP is responsible for a myriad

56. BUPPERT, *supra* note 17, at 14.

57. AM. ACAD. NURSE PRACTITIONERS, NURSE PRACTITIONER MSN TUITION ANALYSIS: A COMPARISON WITH MEDICAL SCHOOL TUITION 1 (Jan. 2010), <http://www.aanp.org/NR/rdonlyres/04789D96-F37C-4550-91BB-29E71BAEC57A/0/NursePractitionerMSNTuitionAnalysisAComparisonwithMedicalSchoolTuition.pdf>.

58. *Id.* at 2.

59. *See id.*

60. *Medical Student Debt*, AM. MED. ASS'N (2009), <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/medical-student-debt.shtml>; *see also* Gail Morrison, *Mortgaging our Future- The Cost of Medical Education*, 352 NEW ENG. J. MED. 117, 117 (Jan. 13, 2005).

61. BUPPERT, *supra* note 17, at 7.

62. Barbara Starfield, *Is Primary Care Essential?*, 344 LANCET 1129 (1994).

63. *Id.*

64. *Id.*

of problems with which patients present. The health issues faced by the PCP are not limited to a single type, or restricted to a single organ system, and the PCP education will have trained the physician to manage a great number of these problems on his or her own.⁶⁶ The PCP is responsible for listening to patients, diagnosing illnesses, managing health-related problems, and screening for additional issues.⁶⁷ A large part of the PCP practice involves acting as patients' coordinator of care.⁶⁸ As the first contact, the PCP will often refer to other health professionals for further evaluation or treatment. For example, an endocrinologist might be consulted for greater specialization and expertise in the case of a patient whom the PCP has diagnosed as diabetic.⁶⁹ Even after referral to the specialist, the PCP shoulders the responsibility for ongoing follow up and continuing care of the patient, seeing to it that the delivered services are adequate.⁷⁰

The NP also plays an important role in the delivery of primary care services. However, because the PCP's scope of practice was defined in general terms to include any phase of a patient's care, when NPs sought legal recognition to provide some primary services, they were seen as "claiming the ability to do tasks which were already included in the universal and implicitly exclusive authority of medicine."⁷¹ As a result, the scope of the NP practice as dictated by local nurse-practice acts varies considerably from state to state.⁷²

Eleven states, including Arizona, permit a NP to work independently without any physician involvement.⁷³ Some state laws allow NPs to set up their own practices, and work independent of physician supervision. NPs are only bound to seek collaboration with a physician when faced with a problem that exceeds their level of expertise.⁷⁴ Nevertheless, a majority of states limit the NP to working only in collaboration with a

65. *Id.*

66. COMM. ON THE FUTURE OF PRIMARY CARE, INST. OF MED., *PRIMARY CARE: AMERICA'S HEALTH IN A NEW ERA* 40 (Molla S. Donaldson et al. eds., Nat'l Acad. Press 1996).

67. *Id.*

68. *Id.*

69. *See id.* at 39.

70. *Id.* at 40.

71. NAT'L COUNCIL OF STATE BOARDS OF NURSING, *CHANGES IN PROFESSIONS' SCOPE OF PRACTICE: LEGISLATIVE CONSIDERATIONS*, 5 (2007), <https://www.ncsbn.org/ScopeofPractice.pdf>.

72. SHARON CHRISTIAN ET AL., *OVERVIEW OF NURSE PRACTITIONER SCOPES OF PRACTICE IN THE UNITED STATES- DISCUSSION* 6 (2007), http://www.acnpweb.org/files/public/UCSF_Discussion_2007.pdf.

73. *Id.*

74. Ariz. Rev. Stat. § 32-1601(15)(a)-(viii) (2010).

licensed physician.⁷⁵ For instance, in Missouri anytime a NP sees a new patient, the patient is required to be seen by a physician within two weeks of the NP visit.⁷⁶ Elsewhere, NPs are prohibited from ordering certain lab tests and prescribing physical therapy, or are required to have physicians co-sign patient charts.⁷⁷ Licensed NPs in each of the fifty states generally have some prescriptive rights, although these rights also vary between jurisdictions.⁷⁸

Because more often than not the NP is limited to practicing under varying degrees of direct supervision by a licensed PCP, the most common role of the primary care NP is that of the “physician extender.”⁷⁹ As the term implies, the NP is hired by the PCP practice to lighten the load of the PCP who is increasingly burdened with high patient volumes resulting from shrinking reimbursement.⁸⁰ The NP provides direct patient care, which can include examination and review of histories, as well as coordination of care, patient education, counseling, and prevention awareness.⁸¹

c. Cost effectiveness

Physician extenders are considered more than mere assistants to the PCP. At just one-third of the starting salary of a new PCP and substantially lower insurance premiums, a NP could be expected to generate three to four times their expense in revenues.⁸² Moreover, this relationship can be exploited to increase the bottom line of the physician-employer’s practice by freeing up time to see more patients per week.⁸³

Other business models are also catching on to the cost-effectiveness of NP care. Retail medical clinics, like MinuteClinic, utilize NPs to deliver convenient, quality, affordable care to patients with common medical conditions. Typical clientele of retail clinics are seeking alternatives to PCPs, urgent care centers, and hospital emergency rooms.⁸⁴ MinuteClinic can quickly accommodate patients with illnesses ranging from coughs and

75. CHRISTIAN ET AL., *supra* note 72, at 6.

76. Nancy Rudner Lugo et al., *Ranking State NP Regulation: Practice Environment and Consumer Healthcare Choice*, 11 AM. J. NURSE PRACTITIONERS 8, 17 (April 2007).

77. *Id.*

78. CHRISTIAN ET AL., *supra* note 72, at 7.

79. Susan F. Dubow, *Adding a Physician Extender*, PHYSICIAN’S NEWS DIGEST (Jun. 1997), <http://www.physiciansnews.com/business/697dubow.html>.

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

sore throats to ear, sinus, and bladder infections.⁸⁵ Although patients cannot receive the full spectrum of care they might receive at their PCP's office, the scope of care offered at MinuteClinic represents 17 percent of all visits to the PCP.⁸⁶ Even more impressive, the costs of managing what amounts to almost eighty million visits to PCPs each year are between 32% to 47% lower when administered by a NP in the retail clinic setting.⁸⁷

As independent clinicians, NPs are cost effective as well. Consider how healthcare providers are reimbursed for services provided in a given patient interaction. Current Procedural Terminology (CPT) is a set of codes that is maintained by the AMA which provides payers with an accurate description of medical and diagnostic services provided to the patient.⁸⁸ For example, if the evaluation of a new patient took twenty minutes, a provider would submit a charge to an insurance company for code 99202.⁸⁹ In Arizona, the non-hospital based PCP would receive reimbursement of around \$68.00.⁹⁰ This figure represents a Medicare reimbursement rate, thus a private insurer will usually pay the provider more for the same service. Although the gap continues to narrow, many NPs are reimbursed at a rate of just 60% to 85% of the physician rate.⁹¹

d. Clinical effectiveness

NPs have been shown to be more than just cost-effective care providers. The clinical effectiveness of the NP has also been demonstrated on several fronts. In response to a request from the Senate Committee on Appropriations, the Office of Technology Assessment (OTA) undertook an extensive review of ten studies that compared the quality of care delivered by an NP and a PCP.⁹² The OTA analysis concluded that the provision of care by a NP is as good as, and in some cases better than, care provided by a

84. MINUTECLINIC, <http://www.minuteclinic.com> (last visited Dec. 5, 2010).

85. *Id.*

86. CHRISTENSEN ET AL., *supra* note 15, at 119.

87. *Id.*

88. *About CPT*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.shtml> (last visited Jan. 29, 2011).

89. *CPT Code Search*, AM. MED. ASS'N, https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp (select Arizona in the State dropdown menu, select Arizona in the City dropdown menu, enter five digit CPT code 99202).

90. *Id.*

91. Rough, *supra* note 19.

92. OFFICE OF TECH. ASSESSMENT, UNITED STATES CONG., *Case study #37, in*, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 3 (Dec. 1986), <http://www.fas.org/ota/reports/8615.pdf> [hereinafter OTA].

PCP.⁹³ The review found that NPs cared for acutely ill patients as well as their PCP counterparts, finding no differences in their competence to prescribe medications or the functional outcomes of their patients.⁹⁴ Remarkably, the OTA did conclude that “NPs appear to have better communication, counseling, and interviewing skills than physicians,” which investigators attributed to the NP’s superior ability to listen to patients, as well as convey instructions regarding the plan of care.⁹⁵

More recently, in 2000 JAMA published a study by Munding and colleagues, comparing primary care outcomes in patients treated by NPs or PCPs.⁹⁶ Although previous studies had demonstrated the quality of care provided by the NP to be equivalent to that of the PCP, this study was controlled and randomized in an environment where NP responsibilities, authority, and patient types were equal to the PCP.⁹⁷ Outcomes were measured by several parameters, including initial visit satisfaction, patient health status, long-term satisfaction, and services utilization within one year of the initial visit.⁹⁸ Enrollees presented with various primary care health issues, including diabetes, hypertension, and asthma.⁹⁹ Investigators found no significant differences between patients treated by a NP and patients treated by a PCP.¹⁰⁰

III. BENDING THE COST CURVE

a. Collaboration vs. Competition

The way to increase affordability of primary care medical services is to increase the ability of the NP to provide independent and autonomous care. NPs are, in many cases, more economical than their PCP colleagues, and have demonstrated the ability to be effective providers of care. Despite these benefits, NPs are exceedingly limited from providing an even greater benefit to the U.S. healthcare system.

One reason is that NPs are embroiled in an unnecessary turf war with the AMA and its

93. *Id.* at 19.

94. *Id.*

95. *Id.*

96. Mary O. Munding et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59, 59 (2000).

97. *See, e.g.*, W. Spitzer et al., *The Burlington Randomized Trial of the Nurse Practitioner*, 290 NEW ENG. J. MED. 251 (1974).

98. Munding et al., *supra* note 96, at 61.

99. *Id.* at 60.

100. *Id.* at 62-66.

PCP members. It seems clear that the AMA is ardently trying to prevent NPs from infringing upon the economic interests of physicians and is using its political clout to achieve this goal. The organization made this clear in a 2006 resolution wherein the AMA explicitly opposed the independent practice of medicine by NPs and any other non-physician.¹⁰¹ Of course, doctors always contend that their vocal support for restricting non-physician providers like NPs from treating patients outside the supervision of a licensed physician is only out of concern for public safety. Is this really the case?

After all, lawmakers and doctors, alike, seem to have little concern over allowing NPs to treat patients who, residing in impoverished and underserved areas, were victimized by physician maldistribution.¹⁰² It is only when considered outside of the low-income, self-pay communities, that increased authority and autonomy of the NP suddenly becomes “[bad] for America.”¹⁰³ Perhaps this is the force behind the fragmented regulations that, in thirty-nine states, keep NPs from being able to set up an independent practice.

Considering the cost of becoming a PCP, it is no wonder physicians are so intent on maintaining their monopoly over the practice of medicine. Unfortunately, the principles upon which that monopoly was granted are broken and outdated. No longer should the responsibility for repayment of medical education rest on the backs of the health care-requiring public. It is in this context that the PCP’s true objections to increased autonomy for the NP come to light.

In an editorial published in JAMA, Dr. Harold Sox concedes that greater competition between NPs and PCPs can lead to a greater standard of care.¹⁰⁴ It is his next comment with which health care consumers should take exception. “That outcome is good for society,” Sox continued, “but it comes at a very high price for the individuals who have invested time and money in becoming health professionals and who are not busy enough to sustain their skills and earn a reasonable living.”¹⁰⁵ With healthcare spending spiraling out of control, should the interests of health professionals be held superior to those of society?

101. See e.g., RESOLUTION: 904 (I-06), AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES, available at http://www.acnpweb.org/files/public/AMA_Resolution_904_11_06.pdf.

102. OTA, *supra* note 92, at 3.

103. Rough, *supra* note 19.

104. Harold C. Sox, *Independent Primary Care Practice by Nurse Practitioners*, 283 JAMA 106, 107 (2000).

105. *Id.*

Contrary to Sox's implication, while the earning of a medical degree and license does grant one a right to be a doctor, it does not guarantee the right to earn a comfortable living. Sox may be correct in his contention that new regulations granting the NP more autonomy to treat common ailments historically reserved for physicians may reduce demand somewhat for PCPs. More accurately, as one of Sox's physician-colleagues correctly points out in her letter to the editor, "the public- as patients and taxpayers- is under no obligation to support whatever number of physicians is produced."¹⁰⁶

There will always be an important role for the PCP in U.S. healthcare. Dr. Sox's comment incorrectly implies that allowing NPs to set up independent practices might eventually render the PCP obsolete. In fact, even with greater NP autonomy, PCPs will still play a prominent role in the provision of primary care services.

b. New Roles for Providers of Primary Care

i. The NP

Let us assume that NP independent practices will offer identical services to those provided at MinuteClinic. Ten common issues currently account for 90 percent of the patient visits to these clinics: upper respiratory infection, sinusitis, bronchitis, pharyngitis, need for immunization, middle-ear infection, outer-ear infection, conjunctivitis, urinary tract infection, and blood pressure or screening lab tests.¹⁰⁷ Despite their high percentage of total volume to MinuteClinic, the combined total of these types of patient ailments account for only 18 percent of visits to *physicians'* offices.¹⁰⁸ So, one can hardly argue that there will no longer be a need for the PCP.

The question here is not whether a NP is as qualified to practice medicine as the PCP. The answer, simply put, is that the NP is not. The real question is whether the PCP is overqualified to provide certain primary care services. Flexner remarked, in his historic report on medical education that "the training of the doctor is therefore more complex and more directly momentous than that of the technician."¹⁰⁹ While that may still be true today, the fact remains, modern technology has transformed the diagnosis and treatment

106. Caroline M. Poplin MD, JD, *Health Outcomes Among Patients Treated by Nurse Practitioners or Physicians*, 283 JAMA 2521, 2523 (2000).

107. CHRISTENSEN ET AL., *supra* note 15, at 120.

108. *Id.*

109. *Id.* at 354.

of many common illnesses into a technical endeavor as opposed to an artful one. Better diagnostic equipment, established evidence-based treatment protocols, and safe, effective pharmacotherapies have changed the way we approach certain illnesses. The identification and treatment of diseases like strep throat, ear infections, and bronchitis is essentially rules-based, and no longer requires significant expertise. As such, it is hard to argue that the PCP is somehow uniquely qualified to prescribe an antibiotic, administer a vaccination, or perform the many ministerial duties of the care coordinator.

Naturally, skeptics will argue that, once given the opportunity to treat patients independently from physician supervision, NPs will push the limits of their knowledge, placing patients in serious danger. However, like their PCP counterparts, NPs can be expected to ethically refer patients to more experienced specialists when a problem is outside their individual scope of expertise. Collaboration between healthcare professionals should always be the standard of the industry.

ii. The PCP

In reality, many diseases remain in the domain of intuitive medicine. That is to say, neither a diagnostic tool, nor established evidence-based rules exist to definitively diagnose and treat most illnesses. This represents the other 82% of primary care office visits, and should remain the dominion of the PCP. In focusing on treating the sickest patients needing primary care services, PCPs will be utilizing the full extent of their expertise. One could envision a situation where PCPs actually performed more like sub-specialists, relinquishing control over the less serious 18% of their practices, and remanding patients back to NPs for effective, less expensive care-coordination services. This scenario is not without precedent. Advances in new therapies have allowed PCPs to effectively treat conditions like allergies, hypertension, depression, conditions that were once far more commonly treated by a specialist. Plus, “as Internet-based decision tools bring the diagnostic capabilities of the world’s best specialists in to the offices of [PCPs]”¹¹⁰, greater numbers of these providers may still be required.

Of course, as technology continues to improve and more rules-based protocols for disease treatment are developed, PCPs will gain ever more patients that were once reserved for their specialist colleagues. All things considered equal, so long as a service

110. *Id.*

can be provided in a quality manner, it is in the best long-term financial interest of the system to encourage the provision of that service by the most economical provider wherever possible. Finding ways to reduce expenditures on routine and ordinary provisions of primary care will free up more economic resources that can be shifted toward the underserved and the higher risk members of our society.

c. Meeting the Demand for Primary Care

Sox's fear of decreased demand for the PCP fails to take into account another critical issue. The nation is experiencing a shortage of PCPs. The American Academy of Family Physicians predicts that the U.S. will need about 40,000 more PCPs in the next ten years.¹¹¹ Meanwhile, the Association of American Medical Colleges predicts this shortage to increase to a staggering 124,400 physicians by 2025.¹¹²

The reason so many newly-minted doctors are extending their residencies and seeking certification as specialists is simple. PCPs are reimbursed far less for evaluation and management of patients than for other services, like surgical procedures. This is the case even though the surgical procedure may be performed in less time than the in-office consultation. For example, while the PCP or Orthopedic surgeon (ORS) would be paid similar figures for the twenty-minute new patient office visit (around \$68.00 as previously discussed), the ORS might receive as much as \$1,100 for ninety minute surgical procedure; the PCP would need to see seventeen patients to earn that amount.¹¹³

The dwindling numbers of PCPs and the perceived inadequacy of reimbursement for their services are having a devastating financial impact on U.S. healthcare expenditures. Though praised as one of the most cost effective providers of healthcare in the country, The Mayo Clinic went so far as to stop accepting Medicare patients in its Glendale, Arizona primary care satellite clinic early in 2010.¹¹⁴ Doctors, at an alarming rate, generally agree that it just does not make business sense to treat public pay patients.¹¹⁵ Of the physicians that continue to see Medicare patients, some resort to a gaming of the

111. Halsey III, *supra* note 12.

112. *Id.*

113. James Rickert, *Primary Care-Lifelines and Shortages*, 361 NEW ENG. J. MED. 1413,1413 (2009).

114. David Olmos, *Mayo Clinic in Arizona to Stop Treating Some Medicare Patients*, BLOOMBERG (Dec. 31, 2009), <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aHoYSI84VdL0>.

115. *Id.*

system; manipulating CPT codes to increase reimbursement for the same encounters.¹¹⁶

Consequently, many patients, Medicare and Medicaid patients in particular, are left without sufficient access to primary care services. Left with few options, more and more of these patients are turning to the hospital emergency room (ER) for basic care.¹¹⁷ In fact, an analysis of ER utilization in New York State, determined that a PCP could have appropriately handled nearly half of all ER visits in 2009.¹¹⁸ The difference in the cost for treating the same condition in an office, as opposed to a hospital, setting can be astronomical. It is estimated that had individuals who sought non-emergency treatment in an ER visited a PCP instead, patients and their insurance companies would have saved up to 90 percent of their expenditures.¹¹⁹ Unfortunately, the dearth of available providers leaves many of these patients with little choice.

Some believe the answer to the shortage of PCPs is higher reimbursement rates for many of the services performed. These proponents of reimbursement equality argue that PCPs' services should be valued as much as the services provided by their specialist counterparts.¹²⁰ While this might provide an incentive for greater numbers of medical students to pursue primary care careers, the unfortunate reality for patients and taxpayers is higher reimbursement for the same services will only lead to even higher costs for health care, and even less access to this essential care.

i. Strength in Numbers

A better solution is to grant legal authority to the nearly 150,000 NPs in America to provide primary care services themselves. As previously mentioned, NP driven centers of care, like MinuteClinic, can provide billions in savings on insurance reimbursements and out-of pocket expenditures.¹²¹ This may just be the beginning. Consider the differing financial incentives of the NP and PCP. Fair or not, it is increasingly clear that the licensed physician is unwilling to incur an enormous medical school debt obligation

116. See, e.g., MEDICAL CODING CASH SECRETS, <http://medicalcodingcashsecrets.com/> (last visited Dec. 4, 2010).

117. STEPHEN R. PITTS, MD ET AL., NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 2006 EMERGENCY DEPARTMENT SUMMARY, 3 NATIONAL HEALTH STATISTICS REPORTS (Number 7, 2008).

118. Josh Green, MD, *Potential Savings Through Reduction of Inappropriate ER Utilization in Hawaii*, HAWAII IPA (2010), http://hawaiiipa.com/media/Document_41.pdf.

119. *Id.*

120. *Id.*

121. CHRISTENSEN ET AL, *supra* note 15, at 120.

for what he perceives to be inadequate reimbursement of his time and service.

In contrast to the PCP, the NP historically has operated with much lower overhead. First, the NP has less educational debt with which to contend. Second, NPs generally earn a fraction of the salary that is paid to a PCP performing the same services. As a result, the NP is much more willing to take on Medicare and Medicaid patients, and can even provide self-pay patients the quality care they deserve at a price they are more likely able to afford. CMS recognizes this important resource and willingly reimburses the NP for services rendered, albeit at 85 percent of the physician level.¹²² Still, this at least establishes the NP as a distinct provider of care in the eyes of the country's most influential payer. The more PCPs refuse to see public pay patients, the sooner CMS may be willing to reconsider its reimbursement levels of non-physician providers who will.

Moreover, in November 2010, a commercial insurer serving Maryland, Northern Virginia, and our nation's capital announced it will, for the first time, allow NPs to participate as "independent primary care providers in its network."¹²³ Additional sources of primary care services translates into fewer patients utilizing our nation's ERs, not to mention restored access to care for Medicare and Medicaid patients. Thus, NP services, in many instances, represent the most efficient use of our limited financial resources.

d. Loosening the Regulatory Reigns

Less regulation could lead to significant savings by eliminating needless oversight and duplication of efforts. In states like Missouri, where visits to an NP must be followed by a visit to a PCP, patients cannot benefit from access to a lower-cost provider of care. Instead, if a patient makes a cost-effective decision to see a NP, they are promptly faced with the additional cost of seeing a PCP, not including the potential hidden costs of travel, or time away from work or family. Elsewhere, in states where NPs are prohibited from ordering basic services, or obligated to have a physician co-sign their charts, costs are certain to rise as a result of requiring two trained professionals to do the job of one. For some reason, performing in the role of the physician extender remains acceptable; possibly because, as a physician extender, the NP continues to serve the economic

122. *Reimbursement Issues*, ILLINOIS SOCIETY FOR ADVANCED PRACTICE NURSING, (Feb. 16, 2011) <http://www.isapn.org/?page=ReimbursementIssues>.

123. Chris Huntemann, *Insurer Expands Primary Provider Status to Nurses*, MARYLAND COMMUNITY NEWSPAPERS ONLINE (Nov. 6, 2010), http://www.gazette.net/stories/11062010/businew85600_32552.php.

interests of physicians.

IV. FUTURE CONSIDERATIONS

Admittedly, any change in the level of independence under which the NP may operate will require the necessary regulatory background in order to have a significant effect. State legislative bodies possess the power to amend their respective Medical Practice Acts, and should take action to enhance the availability and effectiveness of primary care in this country. That is not to say that less regulation of the healthcare industry is required. Instead, lawmakers should carefully consider whether the current regulations limiting the ability of the NP to practice independently actually protect public safety, or simply further physician interests.

Regulations that are “barriers serve no useful purpose and contribute to our healthcare problems by preventing the full deployment of competent and cost effective providers who can meet the needs of a substantial number of consumers.”¹²⁴ Requiring the NP to work under the supervision of a physician limits patients’ access to providers and precludes capable caregivers from stepping up to address the growing shortage of PCPs. States that enforce such regulations do so despite overwhelming clinical evidence of NP competency and limited patient choice. In redefining the scope of practice of the NP, regulators will have the data that exists regarding the clinical effectiveness of NPs’ diagnosis and treatment abilities that have been compiled to date. Regulations should limit the NP to practicing only within areas where competence has been clearly demonstrated, and mandate consultation with physician-providers when the NP is faced with a situation beyond their expertise. In short, NPs should continue working in the capacity that they currently serve, except with the ability to do so independently.

In addition, Medical Practice Acts should require NP governing bodies to develop one uniform educational and licensing program so that the public can feel confident in the requisite training and expertise of new providers. The standardization of MD-granting institutions resulting from the Flexner report has served both physicians and the American public well, and should operate as the basis upon which to produce consistently qualified and well-trained NPs.

124. Lugo et al., *supra* note 76 at 9 (quoting B. Safriet, *Impediments to Progress in Health Care Workforce Policy: License and Practice Laws*, 31 *INQUIRY* 310 (1994)).

Above all, patient safety should be protected. Standardized measures should be developed for identifying and de-credentialing unscrupulous and unethical practitioners. Inherent in this goal is the concept that knowledgeable providers will refer to other providers when confronted with matters beyond his or her capabilities, or when specialty care is necessary for the patient.

V. CONCLUSION

Primary care has been called the “backbone of a rational health services system.”¹²⁵ In fact, in the U.S., analysis has found a positive correlation between the availability of primary care services with health levels.¹²⁶ With national numbers totaling over 150,000 strong, NPs are the optimal solution to lowering the cost of receiving primary care services, and can exponentially increase public access to those services.

NPs have consistently demonstrated the ability to provide quality health care in a cost efficient manner. Unfortunately, when limited to working strictly under the supervision of a licensed physician, any realized benefits of lower cost of care either inure directly to the physician or are eviscerated by unneeded oversight. Either way, it is the practice that benefits and not the public.

As autonomous, independent providers of care, NPs could disperse throughout states providing additional centers of care. NPs are a trusted source of patient management within PCP offices now, and there is no reason to believe that they could not provide the same services on their own.

Health care is evolving, and as such, the delivery of health care must as well. Regulations and predispositions about who is qualified to deliver that care should be reexamined so that the needs of a changing population can be adequately served. Demographic changes, like the aging of the population and the addition of thirty-two million for whom insurance must be funded, have the potential to stretch the U.S. healthcare human and economic resources beyond their limits. Fortunately, advances in technology and evidence-based healthcare procedures have created an opportunity for a new business model of health care delivery- the independent NP practice.

125. Starfield, *supra* note 62.

126. L. Shi, *Primary Care, Specialty Care, and Life Chances*, 24(3) *INTERNAT'L J. HEALTH SERVICES*

