Medical Scope of Practice

The Issue

There are too few doctors for too many patients in Texas, especially outside the major metropolitan areas. More than two million Texans live far away from big cities where the doctors and big hospitals are. Out of Texas' 254 counties, 126 are classified as "medically underserved." And 25 Texas counties have no physician at all.

How are rural Texans, for example in Marble Falls (pop. 6,077) or Raymondville (pop. 9,733), going to get the medical care they need, and particularly in time?

There is one practical way to improve access to care for Texans: realize the full potential of nurse practitioners.

The Arguments

Nurse practitioners (NP) could ameliorate the problem of access to care in these areas but only if they choose to practice there, which they don't because of bureaucratic overreach in the service of protecting existing providers.

Most ailments and injuries can be triaged and even treated by an NP, also known as an Advanced Practice Registered Nurse. When you consider what NPs are able to do, they are not simply nurses but really junior doctors. Given their extensive medical capabilities, NPs could play a much, much greater role in addressing inadequate access to care in remote Texas areas.

NPs are paid less than physicians, which would lead naturally to cost savings. When an NP provides the initial medical triage, cost per episode goes down by at least 20 percent compared to a doctor performing the same function. For what it costs taxpayers to educate one medical student ($160,000), we could educate between three and twelve NPs.

Increased utilization of NPs is not only a cost saver but there are also gains on the revenue side. In 2012, Texas economist Ray Perryman showed that allowing NPs and physicians' assistants to practice to the full extent of their training and without artificial, bureaucratic restrictions could result in an $8 billion increase in gross product per year; add 97,205 permanent new jobs in Texas; and contribute roughly $500 million in additional tax receipts to state and local governments.

Texas fails to realize the full potential of nurse practitioners—both in number and scope of practice—because of the Prescriptive Authority Agreement. This agreement, stripped of legal speak, says that an NP can only function by delegation of authority from a physician, not independently; can only order medications through said delegation; and must comply with (and pay for) chart review by a contract with a physician.

The alleged justification for the Prescriptive Authority Agreement is that chart reviews protect the patients. However, chart reviews are all done after the fact, generally months after the patient encounter. How does such review protect the patient from the adverse impact of an NP's presumed medical mistake, one that happened months previously?

If an NP sets up practice in a small community, where the NP may be the only provider within 50 miles, the delegation and review requirement of the Prescriptive Authority Agreement still apply. The NP can only prescribe medicines under the control of a doctor, even though the NP is well trained in diagnosis and treatment as well as physiology and pharmacology. The rural NP must find and pay a physician to review the NP's charts. Eighty percent of NPs pay in the range of $20,000 per year to their contracting physicians. Some others have to pay as much as $120,000 per year.

The payment required by the Prescriptive Authority Agreement is a form of regulatory extortion the Texas Medical Board or TMB has mandated the Prescriptive Authority Agreement. This board is made up predominantly of physicians who practice within the Texas market, creating a real conflict of interest.

Because of all of the above, Texas cannot make full use of the potential of NPs.

Recommendations

Repeal the Prescriptive Authority Agreement. It provides no benefit to patients and is harmful to Texans by discouraging NPs from practicing in rural communities. ☆

Resources

"NTREC Survey of Physician Workforce in Texas," North Texas Regional Extension Center, 2015 (accessed Sept. 2016).

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