Marquette University
e-Publications@Marquette

College of Nursing Faculty Research and Publications | Nursing, College of

1-1-1989

Payment for Nursing Services: Issues in Policy Implementation

Marilyn Frenn
Marquette University, marilyn.frenn@marquette.edu

Published version. "Payment for Nursing Services: Issues in Policy Implementation," in *Nursing Centers: Meeting the Demand for Quality Health Care*. Ed. National League for Nursing. New York: National League for Nursing, 1989: 43-60. Publisher Link. © 1989 National League for Nursing.

4

Payment for Nursing Services: Issues in Policy Implementation

Marilyn Frenn,MSN, RN

BACKGROUND

The manner in which nurses have been paid in the United States has varied historically, as well as regionally, and by practice specialization (American Nurses' Association, 1977; Hartley & McKibbin, 1983; Harrington & Lempert, 1988; Physician Payment Review Commission, 1988; Poulin, 1985). Although payment mechanisms have been determined in part by federal legislation, recent trends suggest greater involvement in policies affecting nurses will occur at the state level (Aiken, 1984).

The purpose of this chapter is to describe the contexts within which payment varies, issues affecting payment for nursing services, and policy alternatives based on data collected from nurses regarding payment mechanisms in Wisconsin. A plan for policy implementation and evaluation in Wisconsin will be described.

This study was conducted as part of coursework supported in part by an Individual National Research Service Award (NR05946-02) funded by the Center for Nursing National Institutes of Health.

LEGISLATIVE CONTEXTS AND ISSUES AFFECTING PAYMENT OF NURSES

The American Nurses' Association (ANA) began to study the inclusion of nursing services in prepaid health care in 1936 and since has adopted at least 20 resolutions related to third-party payment and recognition of the nurse as a primary care provider (American Nurses' Association, 1984). However, legislative changes enabling direct third-party payment for nursing services have been relatively recent.

Federal coverage for nurse practitioners (NPs), certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNAs) is shown in Table 1. Except for health maintenance organizations (HMOs), coverage included direct payment to the practitioners listed.

State laws also vary in terms which types of nurses receive direct payment

Table 1
Federal Payment Mechanisms for Nursing Specialists

Payer	NP	CNM	CRNA	NPT
Medicare				
Part A	No	No	Not since 1984	?
Part B	No	No	Yes—1984 In 1989	?
HMOs	Yes	Yes	Not applicable	?
State Medicaid	Some states	36 states	8 states	?
CHAMPUS (a)	Yes	Yes	?	Yes
FEHBP (b)	7 plans	20 plans	?	?

NP = Nurse practitioners, masters prepared
CNM = Certified nurse midwives
CRNA = Certified registered nurse anesthetists
NPT = Nurse psychotherapists

? Information not included in sources cited
(a) Civilian Health and Medical Program of the Uniformed Services
(b) Federal Employees Health Benefit Program—21 plans

Sources: American Association of Nurse Anesthetists *CRNA Facts*; Department of Defense, Doc #6010.8-R; Mulinax, 1987; U.S. Congress Office of Technology Assessment, 1986.

for services. States with legislation supporting payment for nursing services are shown by specialty groups in Table 2.

Although professional nursing associations have articulated direct payment of nurses as an avenue toward more autonomous nursing practice (American Nurses' Association, 1984; La Bar, 1983; National League for Nursing, 1981), consumers and those who potentially fund payment of nurses may be concerned that nurses provide care of the quality that they are accustomed to receiving within other payment mechanisms. The endorsements of nursing associations are supported by a number of studies both in the United States and in Canada in which equal or better care delivery by nurses as compared with physicians was documented (Aaronson, 1987;

Table 2
States with Legislation Supporting Payment for Specialty Nursing Groups

CNM

Alaska
Maryland
Massachusetts
Minnesota
Montana
New Jersey
New Mexico
New York
Ohio
Pennsylvania
Utah
West Virginia

NP

California
New Hampshire
Maryland
Mississippi
Montana
Oregon
Nevada

CRNA

Minnesota
Montana

Nurse Psychotherapists

California

Registered Nurses

Maryland
New York
North Dakota
Washington
West Virginia

NP = Nurse practitioners, masters prepared
CNM = Certified nurse midwives
CRNA = Certified registered nurse anesthetists
NPT = Nurse psychotherapists

*In addition Blue Cross/Blue Shield directly reimburses CRNAs in 8 states (American Association of Nurse Anesthetists, *CRNA Facts*).

Sources: ANA (1984); LaBar (1986).

Alfano, 1982; Brooten et al., 1986; Gilbert, 1977; Jacox, 1984; Mayes et al., 1987; Roddy & Hambelton, 1977; Spitzer, 1976; U.S. Congress Office of Technology Assessment, 1986).

However, Jacox (1984) stated that payment for nursing services is largely a political, rather than a research issue. One salient political issue is the effect that providing direct payment to nurses will have on health care costs.

The U.S. Congress Office of Technology Assessment (1986) concluded that extending coverage for the services of NPs, CNMs, as well as physicians' assistants would benefit the health status of certain segments of the population not receiving appropriate care. Although the effects on third-party costs were deemed unclear, a long-term decrease in costs was thought possible with direct nurse payment (U.S. Congress Office of Technology Assessment, 1986). This seems especially likely given that nurses are currently paid one-third to one-fifth as much as physicians (Aiken, Blendon, & Rogers, 1981; American Association of Nurse Anesthetists, 1986).

However LeRoy (1982) documented that NP cost savings may be passed on only to the medical practice or HMO, and not to the consumer. If nurses provide services to fulfill the health care needs of underserved populations, cost increases in the range of 7–15 percent also may be expected (Harahan, 1987), except when nurses and other health professionals provide services directly rather than by referral (O'Malley, 1987). In order to realize either widespread cost reductions or increased services to needy groups, the usage and effects of existing nursing payment mechanisms must be better understood.

CURRENT RESEARCH ON PAYMENT FOR NURSING SERVICES

In their study of nurse entrepreneurs, Vogel and Dolyesh (1988) found that nurses have been quite successful in developing entrepreneurial businesses and consulting firms. Readers also are referred to Bullough, Bullough, Garvey, and Allen's (1985) annotated bibliography concerning third-party payment for nurses on a national basis.

Payment for nursing services in Wisconsin was extensively described in a study commissioned by the Wisconsin Nurses Association (WNA). In this study (Lakewood Group, 1985), federal mandates for payment of nursing specialty groups were described as shotgun in nature and detrimental to overall direct payment for nursing services. No legal barriers to direct payment for nursing services were identified in Wisconsin. Major barriers were identified in individual insurance company contracts that were based on the following perceptions: (1) nurses cannot legally perform independent functions; (2) there is a lack of knowledge about what services nurses can

provide; (3) the physician is viewed as the most appropriate gatekeeper for all health care services; (4) there is a lack of evidence of the marketability of nursing services; and (5) the notion exists that payment for nursing services would generate "add-on" costs (Lakewood Group, 1985).

The Lakewood Group (1985) also found that approximately 40 percent of Wisconsin businesses are self-insured and thus may be responsive to proposals from nurses demonstrating cost-effective care delivery. The survey of WNA members, however, had too few respondents for conclusive data analysis as to whether nurses experienced difficulty in receiving third-party payment or had utilized other methods of payment (Lakewood Group, 1985). Thus, further study of nurses' experiences in obtaining payment for nursing services in Wisconsin still was needed.

METHOD

The purpose of this study was to further describe the experience of nurses in Wisconsin who received direct payment for clinical nursing services. Direct payment was operationally defined as payment for clinical nursing services by clients or third-party payers other than the nurses' employers. Although several of the respondents were also paid for consultation or educational services provided to other professionals, the focus of this study was payment for nursing care provided to individuals or groups.

Since no prior data on usage of direct payment mechanisms by nurses in Wisconsin had been found in the literature, interview questions were developed to discover any forms of payment utilized by nurses, and how payment or the lack of it affected their clients and practice. Ten general informants and 28 nurses representing specific practice settings—including nurse practitioners, certified nurse midwives, certified nurse anesthetists, gerontological nurse specialists, nurses in academic nurse-managed centers, nurse psychotherapists, home care nurses, and community generalist nurses—were asked to respond to the following questions during telephone interviews (three who requested personal interviews were so interviewed):

1. Which means of payment for client services have you found available?
2. Were these means of payment satisfactory for you? For clients?
3. Please describe any other means of payment for nursing services you have heard about.
4. What assets or limitations do you see in third-party (or other) payment for nursing services?
5. What effects might third-party payment have on client utilization of nursing services?

6. If third-party payment were to be pursued further by nurses, additional data bases may be necessary. Do you keep records of client utilization, for example, time spent, type of service, or other such data?
7. Are there other questions that should have been asked, or is there other information you would like to share regarding payment for nursing services?

The response rate was 100 percent, since all persons who were asked to participate agreed to do so. Interviews were generally 15–20 minutes in length. The investigator recorded responses immediately as reported. Copies of an earlier draft of this manuscript were sent to selected respondents in each specialty to check for accuracy of the report as well as maintenance of respondent confidentiality.

Respondents

Respondents included nurses who were generally knowledgeable about payment mechanisms in nursing and nurses who were officers of nursing specialty groups eligible for payment under federal law. Random respondents provided names of specific respondents who they thought might have experience with direct payment for nursing services, even though many specific respondents thus identified were currently in salaried positions. Specific respondents included 7 CNMs, 4 gerontological nursing specialists, 4 NPs, 4 nurses working in nursing centers (NCs) associated with schools of nursing, 3 nurse psychotherapists, 2 CRNAs, 2 home care administrators, and 2 masters-prepared nurse generalists.

Since this project was done as a part of coursework, formal review for protection of respondents' anonymity was obtained upon completion of the report prior to dissemination within guidelines for previously collected data. The interview format was reviewed by two course faculty members prior to data collection. The nature of the study was explained to potential respondents prior to their consent to participate. Confidentiality of response was maintained by reporting data in aggregates without names or characteristics that might be used to identify a particular respondent.

A snowball sampling technique (Bogdan & Biklen, 1982) was used. Each respondent recommended additional nurses with experience in pursuing direct payment who could address the effects of direct payment for clinical nursing services on clients and nursing practice. As a result of this method of sampling, most nurses in the sample practiced within one metropolitan area. However, respondents in other areas of Wisconsin were identified and interviewed within each specialty category except for home care, mental health, and general practice.

Limitations

The small sample size in some respondent categories limited our ability to make generalizations about the findings of this study. The data also reflect payment for specialty nursing services provided primarily by nurses in nonacute care settings who had educational preparation beyond that required for initial licensure.

RESULTS AND DISCUSSION

Nurses in Wisconsin in a variety of specialty practices have found available payment mechanisms. Payment sources for nurses covered by federal legislation are summarized in Table 3.

NURSES COVERED BY FEDERAL PAYMENT LEGISLATION

NPs, CNMs, CRNAs, and nurse psychotherapists all had received payments by clients or third-party payers. However, third-party payment was the exception rather than the rule. Those eligible had claims left unpaid. Client needs exceeding, or not covered by, third-party payments were described by all nurses reporting such payments.

Two different HMOs were described as paying for client services based on nurse–client assessment of need. However, this too was the exception rather than the rule. Some nurses described HMOs as closed systems, while others asked to provide services for HMOs chose not to do so because of the paucity of services covered and low level of payment.

Nurses in Wisconsin within these specialties for the most part had not used federal payment mechanisms. Reasons cited included the lower level of payment provided by governmental sources for services provided by nurses rather than physicians, legally mandated physician collaboration, and lack of coverage by private insurers when identical services were provided by nurses. These reasons made usage of the physician rather than nurse provider number financially advantageous when nurses were employed in clinics, and also made independent nursing practices unfeasible. Specific examples in each practice category are described as follows.

Nurse Practitioners

The four NPs included in this category were those educationally prepared as NPs whose practice was not primarily in gerontological care or in academic

Table 3
Payment Source Utilization in Wisconsin: Nurses Paid through Federal Mechanisms

Payer	NP	CNM	CRNA	NPT
Medicare				
Part A	No	No	Before 1984	In clinics with physician collaboration
Part B	No	No	Yes—1989	
Medicaid	No	Yes	No	As above
CHAMPUS	No	NR	No	No
Private Insurers	No	No	As hospital employees	Yes
HMOs	No	No	As hospital employees	Yes
Agency Contracts	Yes	Salary paid by physicians	Possible	Yes
Private pay	Yes	Yes	Possible	Yes
Grants	NR	NR	NR	NR

NR = Not reported by respondents in ths study
NP = Nurse practitioners, masters prepared
CNM = Certified nurse midwives
CRNA = Certified registered nurse anesthetists
NPT = Nurse psychotherapists

nursing centers. These NPs were predominantly in salaried positions and used their physician's provider number for insurance claims.

One nurse practitioner lost her home care provider number because she was working with a physician and there was concern about possible duplicate billing for the same service. Some insurers would not pay unless a physician's name was on the form. The fact that most NPs were in practices with physicians and are legally dependent on physicians was seen as a factor restraining direct payment for NPs.

In one case, NP charges for identical services were the same as physician's

charges. In two other cases, NPs charged less (half as much, in one case) as physicians.

Therefore, because of legally mandated physician collaboration, federal payment mechanisms available to NPs have not been used in Wisconsin. Potential cost savings to consumers that might have accrued from direct payment instead have gone to physician practices.

Certified Nurse Midwives

All seven CNMs interviewed described themselves as currently or previously employed in salaried positions in clinics or with physicians. Although CNMs had obtained Medicaid payment numbers, payment for CNM services were billed through physician or clinic provider numbers. The CNM respondents did not express dissatisfaction with being paid a salary.

However, CNMs described problems with current reimbursement mechanisms in terms of independent practices for nurse midwifery. These problems included the facts that (1) private insurers often would not pay for deliveries by CNMs, therefore clients went elsewhere; (2) Medicaid payment alone was insufficient to support independent midwifery practices since CNMs are paid at 80 percent of the $450 fee allowed physicians, whose customary fees exceed $1000; (3) Medicaid payment required membership in an HMO in certain counties, and HMOs were seen as closed systems that, except in one instance, would not pay for midwifery services; and (4) Medicaid paid only for 6-week postpartum visits, and not for family-planning teaching or other services usually provided by CNMs.

Thus, the experiences of CNMs parallel those of NPs in that disparities in payment to CNMs through Medicaid, compounded by limited private payment mechanisms, made independent practice unfeasible. Any cost savings resulting from lower CNM salaries relative to physicians did not accrue to consumers, but rather to physicians or clinics employing the CNMs.

Certified Registered Nurse Anesthetists

According to the two respondents, all CRNAs in major metropolitan areas were employed by hospitals. Wisconsin was described as not yet having any insurance plans that directly pay the 350-400 CRNAs practicing at this time.

Again, any cost savings from CRNA practice accrued to hospitals, rather than directly to consumers in Wisconsin. Therefore, since in 1984 50–70 percent of anesthesia services were provided by CRNAs, who were paid one-third to one-fourth as much as anesthesiologists (American Association of Nurse Anesthetists, 1986), the cost savings are most likely substantial.

As with the other nursing specialty groups in Wisconsin who have federally

authorized payment for services, but who by law must collaborate with physicians, CRNAs largely have not used these payment sources.

Nurse Psychotherapists

For the three nurse psychotherapists interviewed, direct payment by clients was the most frequent method of payment. They did not report the use of federally mandated CHAMPUS payments. Payment by some private insurers was reported by a doctorally prepared nurse, but was only available to masters-prepared nurses with physician coverage.

HMOs were reported as largely problematic for nurses due to low coverage for services, low payments to nurses, and infringements on the nature of nursing practice. Mandated physician coverage that leads nurses to work in clinics absorbed 40–60 percent of the fees generated by nurses.

One doctorally prepared nurse described payment as satisfactory, while a masters-prepared nurse said the income from independent practice was insufficient to live on. Lack of continued visitation privileges to see hospitalized patients was problematic in terms of continuity of care.

Thus, greater usage of third-party payment was reported for nurse psychotherapists than for other groups. However, direct client payments were the greater source of revenue. Income was sufficient in one of the three cases, where the nurse received payment without mandated physician coverage.

NURSES NOT COVERED BY FEDERAL PAYMENT MECHANISMS

Payment source utilization for nurses in academic nursing centers, gerontological specialists, home care, and nurse generalists is summarized in Table 4. These nurses, not covered by federal payment mechanisms, reported contracts with housing agencies, county health programs, and institutions providing employee benefits as alternate payment mechanisms. Other nurses were paid on a fee-for-service basis, sliding payment scale, or provided free nursing care. Services included primary care for individuals as well as group classes and health screenings. Specific examples in each practice setting are as follows.

Academic Nursing Centers

Payment in academic nursing centers affiliated with schools of nursing was varied. Methods included fee for service, contracted care, HMO payment, membership fees, donations, grants, and nursing services provide free of charge by students and faculty either as part of their contract with the school or as community service.

Table 4
Payment Source Utilization in Wisconsin:
Nurses Not Paid through Federal Mechanisms

Payer	Nursing Center	Gerontological Specialist	Home Care	MSN Generalist
Medicare				
Part A	No	No	NA	No
Part B	No	No	With physician order	No
Medicaid	No	No	As above	No
CHAMPUS	No	No	No	No
Private Insurers	No	No	With physician order	Yes
HMOs	1/4	No	1/2	Yes
Agency Contracts	Yes	Yes	NA	Yes
Private Pay	Yes	Yes	Yes	Yes
Grants	Yes	Yes	NR	NR

NR = Not reported by respondents in this study
NA = Not applicable

Two NCs utilized fee for service as a primary method of payment. Three NCs also contracted with other agencies to provide specific programs or services such as physical examinations, childbirth education, and cardiopulmonary resuscitation training. One NC had received payment from an HMO within the $30 per-client per-year that HMO allocated for health promotion. Two NCs were building files of claims rejected by HMOs or insurance companies.

One NC operated with membership fees. Another requested that clients make free-will donations (amount unspecified). One NC had originally purchased equipment with foundation grant moneys. Some nursing services were provided free of charge by faculty and students. In another NC, faculty practice was included as part of their contract with the school. In the

remaining three NCs faculty volunteered as a community service or were paid for the particular class or service they offered.

Third-party payment was being pursued further in two NCs. Respondents advocated personal contact, involving consumers in requesting that services be covered, statewide nursing organization efforts to facilitate direct payment, and building a file of unpaid claims with which to make a case for payment with those companies who refused.

Records are kept at all NCs concerning frequency and type of client visits. Two NCs utilize forms with information requested by insurers. One NC has set up a mechanism for cross-tabulating time spent, nature of the visit, and the fee schedule. Research also has been conducted in two NCs related to nursing diagnoses utilized in those nursing practices, should nursing diagnoses be developed as a payment mechanism.

Gerontological Nurse Specialists

The four nurses interviewed who were caring for the elderly had a variety of educational backgrounds and a variety of payment mechanisms. Educational preparation included diploma, nurse practitioner, masters degree in nursing, and an earned doctorate. Payment was achieved by contracts with managers of housing for the elderly and senior centers, through grants from United Way, the Office of Aging, church-related institutions, a hospital, through private payment in a joint practice with a physician, and by salary.

The nurse who had been in joint practice with physicians expressed equivocal satisfaction with the arrangement. She stated it was difficult because there were no other nurses and it took a while to "prove a track record." In the joint practice model, nursing services were billed at $7 per 15 minutes.

The same nurse is now salaried in an adult day-care program paid for through a combination of public and private funds. She said some clients probably did not know that the nurses were paid and that the type of service provided was difficult to price. She described a number of problems that were averted in terms of medication management, crisis management, recognition of problems at a stage where intervention prevented a medical problem, and helping people to find a physician when they had not already established such a relationship.

Another nurse had contracted with a congregate housing project whereby nursing care was prepaid along with rent. In one case, when a minimal fee-for-service stipulation was added, client utilization dropped to zero. The contractual arrangement was described as satisfactory for nursing. However, the nurse was then vulnerable to housing-management decisions regarding continuity of the service and choice of educational and pay level of the practitioner. Such a contract also meant that the nurse needed to facilitate

patterns of usage in order not to miss people who needed the services, but perceived the nurse as too busy.

Another nurse has worked as an independent practitioner through contracts with a county and by offering nursing services in churches and in shopping centers. When she first started her practice, she wrote to doctors in order to generate referrals. One doctor referring a client reduced billing costs by 25 percent.

The county she contracts with pays her a flat rate of $15 per hour. She has "had no luck with Medicaid." She described the $15 per hour rate as satisfactory because she had little overhead except for her car, otoscope, sphygmomanometer, and blood glucose equipment.

The care she provides through the church is "free care." Some churches have requested blood pressure screenings without any in-depth counseling. Other churches have requested home care and nursing services in greater depth. She sees one benefit of her service in the opportunity to help others as she does not attend church regularly.

Another nurse, who owns community housing for the elderly, contracts for nursing services as part of the package. Nurses are paid $100 per month for supervising the health care of eight elderly residents. This pay includes two half-day visits per month to each house and response to phone calls residents or housing staff make to the nurses during the month. Nurses are paid $25 for assessments that are done prior to a resident's acceptance into the community housing. They are also paid additionally for workshops that they provide for housing staff.

Thus, a great variety of payment sources apart from third-party payments, were utilized by gerontological nurse specialists. However, payment for nursing services for the most part did not generate an income sufficient to live on and nurses either had to accept additional salaried positions, or were not the sole providers of financial support in their households.

Home Care

Two nurses were asked to describe their experiences regarding payment for home care nursing services. One nurse had started a home care agency and the other directed a proprietary agency. Because the regulations, number of agencies, and issues pertinent to home care alone would require a large study, data reported here are limited to a brief overview.

The nurse starting a new agency initially saw patients for free to generate the documentation necessary for obtaining a certificate of need and subsequent Medicare certification for psychiatric home care. Other insurance companies have also since paid for services of this agency. However, client needs usually were greater than the 40 visits customarily covered, so clients and their families then paid for care.

This respondent stated that she can no longer afford to accept clients with one major insurance company unless the clients agree to pay out of pocket. She described that company as being $20,000 behind in payments, and then only paying two percent per month.

Another nurse, who manages the metropolitan office of a nationwide proprietary home care agency, was also interviewed. This nurse reported that most of her clients paid with private insurance or out of pocket, although a few were covered by Medicare or Medicaid.

This respondent described home care as an area where many clients "fall through the cracks" in terms of having needs that Medicare does not cover, such as those who are not home-bound and may only need help with a bath. She described the $9 per-hour charge as more than what people on fixed incomes could afford to pay. Yet this rate was described as less than what nonproprietary agencies would charge for the same services.

The $20,000 in unpaid claims described by the first respondent was viewed as minor by this respondent in terms of that particular insurance company's overall unpaid claims. One HMO was described as covering home care services based on the nurses' assessment of client needs. However, this was not usually the case. Other HMOs were described as varying considerably in payment mechanisms. Services covered were described as not well defined, and were therefore dependent on the mood of the person with whom a home care agency happened to be dealing.

The experiences of home care nurses thus indicated that even when third-party payment was provided, collection of the payment was difficult, client needs exceeded the amount covered, and fees often exceeded clients' ability to pay. Coverage based on nursing assessment did occur, but most third-party payers required a physician order.

Nurse Generalists

Both nurse generalists interviewed were paid on a fee-for-service basis with a sliding scale based on ability to pay. Neither had been able to generate a profit above expenses. One practice ended after three years; another had been operating for six years.

In one case clients submitted their own claims for reimbursement and some were reimbursed by third-party payers. The other nurse interviewed had been reimbursed twice by a third-party payer and once by workmen's compensation benefits.

One nurse described her basic rates as $15 per hour for a workshop, $25 per hour for a hospital or home visit. She also had been paid $20 per hour as a nurse consultant for a physician group and had been paid through an agency for home health Title 18 visits.

The nurse generalists interviewed had found payments insufficient to

support a practice financially. Problems in procuring third-party payment also were described by nurse generalists in that insurers did not recognize the services provided as payable services, such as outpatient counseling for post-partum depression or respite services for new patients or others caring for disabled persons.

SUMMARY

The respondents presented a picture of payment in Wisconsin that varied among specialty groups and among practitioners within each specialty group. Some nurses in each category had been paid directly, but this tended to be the exception rather than the rule.

Even when nurses were paid by third-party payers, client needs were reported as exceeding coverage, payments were difficult to collect, and in most specialty areas, payments received were insufficient for nurses to live on unless other sources of income were available. Records of client utilization, time spent, and types of service were kept by at least some members of each specialty group should such data be needed in further research.

POLICY ALTERNATIVES AND ANALYSIS

Based on the findings in this survey, it is evident that (1) the goal of strengthening nurses' control of nursing practice requires high priority, and (2) educational offerings dealing with payment issues are necessary across specialty groups so that payment sources utilized by some may be expanded to all areas of nursing practice. Additional attention to legislative changes mandating direct payment for nurses does not appear to be indicated at this time.

The caution against mandatory payment is based on the lack of support for mandatory payment and conclusion that the blocks to direct payment are largely perceptual and political on the part of insurers and HMOs identified by the Lakewood group (1985). Since third-party payments have been insufficient, difficult to collect, and inadequate in meeting clients' nursing-care needs even when nurses were included as providers, alternative sources of payment also need to be developed.

Boneparth (1982) described enhancement of equity as a value many would ascribe to making policy changes. Therefore changes in policy to increase direct payment of nurses would be best supported by evidence that such changes improve equity, but do not increase costs, decrease quality of care, or put other health care providers at risk of diminished tangible or intangible benefits.

The strongest case for equity would seem to be built by realizing (1) that 450,000 people in Wisconsin were uninsured (Reimer, 1984 cited in Murphy, 1986); (2) the usefulness of independent nursing practice as a means of addressing underserved populations (McKibbin, 1982); (3) the cost-effectiveness both for meeting the needs of underserved populations and decreasing overall health care costs, given that nurses are paid only one-third to one-fifth the amount physicians are paid for provision of identical services of equal or better quality (Aiken, Blendon, & Rogers, 1981; Jacox, 1984; U.S. Congress Office of Technology Assessment, 1986); and (4) the decreased client utilization of nurse providers whom insurers refused to pay (as supported by respondents in this study). The files of rejected insurance claims as well as records kept by nurses providing free nursing services identified by respondents in this study, also would support the case of inequity by identifying the need for independent nursing services and the current lack of payment.

Based on the findings of this study, it is recommended that nursing continuing education providers undertake the task of continuing education about direct payment issues. Invited papers reflecting data bases of nursing utilization and costs for clients could be distributed to conference participants and potential third-party payers.

Additional input for such a conference might be pursued by contacting businesses pursuing self-insurance mechanisms. These businesses also may be potential financial contributors to a conference exploring quality, cost-effective health care provision. Nurses can then use this information to better involve clients in pursuing direct payment as well as to inform employers, third-party payers, and legislators about options for quality, cost-effective health care.

REFERENCES

Aaronson, L. S. (1987). Nurse-midwives and obstetricians: Alternative models of care and client "Fit". *Research in Nursing and Health, 10,* 217–226.

Aiken, L. H. (Ed.) (1984). *Nursing in the 1980s crises, opportunities, challenges.* Philadelphia: J. B. Lippincott.

Aiken, L. H., Blendon R. J., & Rogers, D. E. (1981). The shortage of hospital nurses: A new perspective. *Annals of Internal Medicine, 95,* 365–372.

Alfano, G. J. (1982). Hospital-based extended care nursing: A case of study of the Loeb Center. In L. H. Aiken (Ed.), *Nursing in the 1980s crises, opportunities, challenges* (pp. 211–228). Philadelphia: J. B. Lippincott.

American Association of Nurse Anesthetists. (1986). *CRNA facts.* U.S. Congress: Office of Technology Assessment.

American Nurses' Association. (1984). *Obtaining third-party reimbursement: A position statement of the Commission on Economic and General Welfare.* Kansas City, MO: Author.

Bogdan, R. C., & Biklen, S. K. (1982). *Qualitative research for education: An introduction to theory and methods.* Boston: Allyn and Bacon, Inc.

Boneparth, E. (1982). A framework for policy analysis. In E. Boneparth (Ed.), *Women, power, and policy* (pp. 1–14). New York: Pergamon Press.

Brooten, D., Kumar, S., Brown, L., Butts, P., Finkler, S., Bakewell-Sachs, S., Gibbons, A., & Delivoria-Papdopoulos, M. (1986). A randomized clinical trial of early hospital discharge and home follow-up of very low birth weight infants. *New England Journal of Medicine, 315,* 934–939.

Bullough, B., Bullough, V. L., Garvey, J., & Allen, K. M. (1985). Third-party reimbursement for nurses. In B. Bullough, V. L. Bullough, J. Garvey, & K. M. Allen (Eds.), *Issues in nursing and annotated bibliography* (pp. 130–134). New York: Garland.

Gilbert, J. (1977). Outcome - experience and training of the anesthetist. In R. A. Hirsch (Ed.), *Health care delivery in anesthesia* (pp. 143–150). Philadelphia: George F. Stickly Co.

Harahan, M. (1987). *National long-term care channeling demonstration: Abstracts of reports.* Washington DC: Department of Health and Human Services.

Harrington, D., & Lempert, L. (1988). Medicaid: A public program in distress. *Nursing Outlook, 36,* 6–8.

Hartley, S., & McKibbin, R. C. (1983). *Economic and employment issues in nursing education.* Kansas City, MO: American Nurses' Association.

Jacox, A. K. (1984). Prospective payment: Focus on clinical nursing research. In C. A. Williams (Ed.), *Nursing research and policy formation: The case of prospective payment.* Kansas City, MO: American Academy of Nursing.

LaBar, C. (1983). *Third party reimbursement for services of nurses.* Kansas City, MO: American Nurses' Association.

LaBar, C. (1986). Legislation affecting the autonomy and credibility of nursing practice. *State Nursing Legislative Quarterly, 4*(1), 13–14.

Lakewood Group. (1985). *Analysis of reimbursement for nursing services in Wisconsin.* Madison, WI: The Wisconsin Nurses Association.

LeRoy, L. (1982). The cost effectiveness of nurse practitioners. In L. H. Aiken (Ed.), *Nursing in the 1980s crisis, opportunities, challenges* (pp. 295–314). Philadelphia: J. B. Lippincott.

Mayes, F., Oakley, D., Wranesh, B., Springer, N., Krumlauf, J., & Crosby, R. (1987). A retrospective comparison of certified nurse-midwife and physi-

cian management of low risk births. *Journal of Nurse-Midwifery, 32,* 216–221.

McKibbin, R. C. (1982). *Nursing in the '80s: Key economic and employment issues.* Kansas City, MO: American Nurses' Association.

Mullinax, K. (1987). Compliance with Medicaid reimbursement law as of November 1986. *Journal of Nurse-Midwifery, 32*(3), 159.

Murphy, E. K. (1986). Health care: Right or privilege. *Nursing Economics, 4*(2).

National League for Nursing. (1981). *Position statement on reimbursement for nursing care.* New York: National League for Nursing.

O'Malley, K. (1987). Nursing delivery systems that respond to emerging needs of special populations. *Post conference papers: National Commission on Nursing Implementation Project.* Milwaukee, WI: National Commission on Nursing.

Physician Payment Review Commission. (1988). *March 31, 1988 Report to Congress.* Washington DC: The Commission.

Poulin, M. A. (1985). *Configurations of nursing practice.* Kansas City, MO: American Nurses' Association.

Reimer, D. R. (1984). *Insuring Wisconsin's uninsured. Report submitted to the Wisconsin Department of Health and Social Services.* Madison, WI. November 12, 1984. Cited in Murphy (1986).

Roddy, P. C., & Hambelton, R. (1977). Supply, need and distribution of anesthesiologists and nurse anesthetists in the U.S. 1972 and 1980. *Medical Care, 15,* 750–766.

Spitzer, W. O. (1976). Evidence that justifies the introduction of new health professionals. In P. Slayton & M.J. Trebilcock (Eds.), *The professions and public policy* (pp. 211–236). Toronto: University of Toronto Press.

U.S. Congress Office of Technology Assessment (1986). *Nurse practitioners, physician assistants, and certified nurse-midwives: A policy analysis* (Health technology case study 37, OTA-HCS-37). Washington DC: US Government Printing Office.

Vogel, G. & Dolyesh, N. (1988). *Entrepreneuring: A nurse's guide to entrepreneuring and consulting.* New York: National League for Nursing.