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## Public Policies that Shaped the American Physician Assistant

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### ABSTRACT

**Introduction:** The American physician assistant (PA) was created through a series of federal policies and legislative acts. Each was intended to improve society through advancements in the delivery of healthcare. The theory why this public policy developed has been unexplored.

**Method:** A search of reports was undertaken to identify national legislation that enabled the PA to be included in the American medical workforce. The effect was a chronology of federal acts and policies.

**Results:** In the early 1960s editorials, conference proceedings, and reports signaled that more access to physician services was needed for a growing American society. Beginning in 1965 with a series of congressional acts such as Medicare and Medicaid, a call was made for a physician analog. Envisioned was a type of assistant who could undertake many of the routine responsibilities of the doctor. Half a century later the number of clinically active PAs exceeds 120,000 and 260 PA programs are operational. What policies gave impetus to this novel health workforce innovation? All the acts and policies produced by Congress or federal agencies that involved PAs were analyzed, summarized, and placed in chronological order. The result reveals an evolution of healthcare reform that continues well into the 21st century.

**Conclusion:** From 1966 to 2024 (58 years) there were 18 significant federal acts, policies, and improvements that enabled PAs to provide medical services in American society. With each enactment drawing on the success of preceding ones, more expansion of the PA took place and their utilization grew.

### 1. Introduction

Introduced in 1965, physician assistants (PAs) emerged as an important addition to the medical workforce in the United States [1,2]. As of 2020 there are approximately 120,000 clinically active PAs and 260 accredited educational programs [3,4]. In the span of half a century this health professions development has been a subject of interest to policy analysts as the nation grapples with a shortage of physicians. From three graduates in 1967 to approximately 10,000 graduates in 2020, the demand for PAs has yet to plateau. The Bureau of Labor Statistics (BLS) predicts the growth will be 31% between 2019 and 2029 [3]. How did this happen and what were the policies that produced this deployment of PAs in American society?

Beginning in the mid-1960s, the training and utilization of PAs became part of a federal health policy strategy that included expansion of undergraduate medical education, the subsidization of graduate medical education, and the introduction of “non-physician” medical providers [5]. While the attainment of enabling legislation and regulation by state medical licensing boards was a necessary part of their deployment, federal

health workforce innovations, incentives, and policies were also influential in assuring the establishment of the PA profession. In the absence of consolidated public policy literature on PAs, we set out to address those that appear to have had the greatest impact on the development of the PA profession. The research question we explored is: *What were the federal policies and acts that contributed to the development of the PA profession?*

### 2. Method

A literature search was undertaken of publicly available information and reports about federal legislation that enabled the PA to be included in the American medical workforce. This was aided by documents and reports that were archived in the PA History Project (<https://pahx.org>), the American Academy of Physician Assistants (<https://www.aapa.org>), National Library of Medicine (<https://www.nlm.nih.gov>) and the Federal Depository Library Program (<https://www.fdlp.gov>). The results were discussed, and reviewed for inclusion, then arranged chronologically, and a brief synopsis added.

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### 3. Results

From 1966 to 2024 (58 years) 18 significant federal acts and policies have enabled PAs to provide services in American society (TABLE).

#### TABLE FEDERAL ACTS AND POLICES THAT PERTAIN TO PHYSICIAN ASSISTANT DEVELOPMENT

**1966 Allied Health Professions Personnel Act of 1966.** The initial act that permitted PA education programs to develop.

**1968 Health Manpower Act of 1968 (Public Law 90-490).** Establishes funds for demonstration projects in healthcare delivery.

**1971 Comprehensive Health Manpower Training Act of 1971** – Congress includes \$4 million for establishment of new PA educational programs in 1972. This Act significantly modified the *Health Professions Educational Assistance Programs* section contained in the Public Health Service Act of 1944.

**1972 Title VII Section 747 of the Public Health Service Act.** This act is the only source of federal funding that directly supports PA programs. Every few years a series of competitive grant awards are made to qualifying PA programs that are able to (1) show they can increase the supply of generalist providers, (2) better balance the distribution of providers to rural and medically underserved areas, and (3) improve the diversity of the health workforce [6].

**1972 Title VII of the Public Health Service Act is related to the passage of the Medicare program in 1965.** In 1972 the federal government started promoting the training and utilization of new types of health care professionals including PAs [7]. This started with the Health Professions Education Assistance Act (PL 88-129), that was an amendment to Public Health Service Act 42 U.S.C. of 1944, and the first of its kind to address the supply of healthcare professions [8].

**1976 The Health Professions Educational Assistance Act (HPEA) of 1976.** Establishes PA education program funding as a separate section of health education legislation. The 1976 HPEA promotes the development and utilization of the health professions through financial grants. The Act targets four major problems of the American healthcare system: (1) the shortage of health professionals; (2) the geographic maldistribution of medical providers; (3) the specialty maldistribution of physicians and dentists; and (4) the influx of international medical graduates into the United States. It does this through: (1) amendments to the direct federal loan program for students in health profession schools; (2) increases in the authorization of funding to programs such as the National Health Service Corps (NHSC); (3) placing requirements on health profession schools for capitation support; and (4) enhancement of the existing Area Health Education Centers (AHEC) program [9].

**1977 Rural Health Clinic Services Act of 1977.** Passed by Congress and signed by President Carter the intent was to improve rural health. The Act provides Medicare reimbursement for services provided by PAs, and Advance Practice Registered Nurses (APRNs [NPs and CNMs]) in certified rural health clinics (RHCs). Medicare pays RHCs an all-inclusive rate for medically necessary, face-to-face primary health services and qualified preventive health services furnished by an RHC practitioner [10].

**1986 Omnibus Budget Reconciliation Act of 1986.** Congress authorized reimbursement of services performed by PAs and APRNs when furnished in a hospital, nursing home, or as an assistant in surgery. A 1987 amendment added services furnished in a physician's office located in a 'rural health manpower shortage area'. The objective was to improve medical services to nursing

home residents through Medicare & Medicaid reimbursement beginning in 1989.

**1993 Drug Enforcement Administration (DEA)** registers PAs who are authorized to prescribe and dispense controlled substances. The DEA assigns the term "mid-level practitioner" (MLP) for PAs and other non-physician prescribers. As a federal agency the DEA is authorized to inspect and copy certain state required documents relating to licensure.

**1997 Balanced Budget Act.** Signed by President Clinton, the act reforms some of the provisions in Medicare and Medicaid and recognizes PAs and APRNs as covered providers in all settings at a uniform rate of payment for the first time [11].

**2000 PA Advisor in the Veterans Health Administration (VHA).** Congress creates a role for a PA Advisor to the director of the VHA. This PA elevated role matches the Director of Nursing in the VHA. The advisor becomes involved in staffing recommendations.

**2003 The Centers for Medicare and Medicaid Services (CMS)** expands the ability of PAs to have an ownership interest in a practice and be reimbursed by Medicare & Medicaid. With this policy reimbursement by Medicaid, TRICARE and nearly all private payers cover medical and surgical services delivered by PAs.

**2003 PAs are appointed to Federal Advisory Committees by the Department of Health and Human Services (DHHS).** The committee oversee areas of medicine of particular interest to the PA profession, e.g., primary care training, rural health initiatives and human services. PAs are included as members of the Title VII Advisory Committee within DHHS [12].

**2008** – Senate Bill 1155 authorizes a full-time **PA Director of VA Services** in the Department of Veterans Affairs Central Office in Washington, D.C. This office advises the Director of the of VHA regarding staffing of medical services with PAs.

**2010 Patient Protection and Affordable Care Act (ACA)** was signed by President Obama with an implementation timeline through 2014. Provisions of the act, when fully established, added 30 million persons to the ranks of those who are fully insured. The need for additional medical services, especially in primary care, was seen as greater than anything seen since the implementation of Medicare and Medicaid in 1966. The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010.

**2010** In addition, the ACA funded a Health Resources and Services Administration program titled – "**Expansion of PA Training (EPAT) Program**". This ACA clause provided \$32 million in funding for Federal fiscal years 2010 through 2014 for PA education.

**2017 The Choice and Quality Employment Act of 2017, Section 212,** requires PAs employed by the U.S. Department of Veterans Affairs to receive competitive pay by changing 38 U.S. Code § 7451 to include PAs as a "covered occupation" in the Nurse Locality Pay System.

**2018 Medicare Patient Access to Hospice Act of 2017.** Congress passed into law a provision that allows PAs to manage and provide hospice care to Medicare patients. <https://www.cms.gov/media/125141>

**2019** Proposal accepted by the Office of Management and Budget (OMB) for PAs to receive \$1,000.00/year for **Continuing Medical Education (CME)**; the same reimbursement as paid to physicians.

**2019 MedPAC Report to Congress.** The Medicare Payment Advisory Commission recommends (by 17 to 0) that "incident to" billing be eliminated for PAs and APRNs. This recommendation is for full reimbursement for all services and eliminates the "incident to" clause that reimburses PAs and APRNs at 85% of the prevailing rate [13].

**2020 CMS Waiver** during the Covid-19 crisis. CMS issues waivers so that hospitals can use PA and APRNs to the fullest extent possible in accordance with a state's emergency preparedness or pandemic plan during the SARS-CoV-2 pandemic. Physician supervision is waived during this crisis of 2020.

**2020 President Trump Expands Telehealth Benefits** for Medicare Beneficiaries During COVID-19 Outbreak. Reimbursement includes PAs and APRNs.

The Center for Medicare and Medicaid Studies (CMS), a federal agency of DHHS, finalized permanent policy to authorize PAs to "certify, establish and periodically review the plan of care, as well as supervise the provision of items and services "for **home health services** for Medicare and Medicaid beneficiaries with a retroactive effective date of March 1, 2020." Individual PAs are to ensure this is consistent with State law, scope of practice, and institutional policy.

The AAPA-supported legislation included in the **Coronavirus Aid, Relief, and Economic Security (CARES) Act**, signed on March 27, 2020, authorized PAs to certify home health care and establish/review a plan of care under Medicare and provided a statutory directive to apply this same authorization to Medicaid. Language contained in an interim final rule formalized the policy changes made in the CARES Act for PAs and applies to Medicare and Medicaid. Additional information is available in AAPA's PAs and Home Health reimbursement brief (<https://connect.aapa.org/login?client=aapawebsite&returnUrl=https%3A%2F%2Fwww.aapa.org%2Fno-access%2Fdownload-id%2F5047%2F>).

**2024 Improving Access to Cardiac and Pulmonary Rehabilitation Act.** This Act goes into effect Jan. 1, 2024, to allow PAs and APRNs to supervise cardiac and pulmonary rehabilitation programs for Medicare patients. <https://www.congress.gov/bill/115th-congress/senate-bill/1361>

#### 4. Discussion

Federal policy enactments have been critical to the growth and institutionalization of the American physician assistant profession in two particular areas: (1) promotion of educational programs, chiefly those with an emphasis on primary care, and (2) establishment of public payment systems and regulations to authorize reimbursement for PA-provided services. Government support was an important influence in moving the nascent PA profession toward primary care. Federal policy incentives for PA training programs came to have a significant bearing on the direction of the PA profession in its first and second decades. During the first era of development as a health profession, more than half of practicing PAs worked in primary care [14]. As of 2020 less than one third of all PAs are in a primary care specialty. Instead they are widely dispersed across 65 different medical and surgical specialties (NCCPA 2020).

##### 4.1. Educational support

Following the creation of the Duke University PA Program in 1965 and the Medex movement at the University of Washington in 1969, a period of federal activism in the health sector of America ensued. This included the passage of the Medicare program in 1965, the inclusion of graduate medical education (GME) as part of Medicare, the expansion of undergraduate medical education and the funding of Community Health Centers. To accomplish all this the federal government promoted the training and utilization of new and existing healthcare professionals including PAs and APRNs [15–17]. The Health Professions Education Assistance Act (PL 88–129 - HPEA), an amendment to Public Health Service Act 42 U.S.C. of 1944, was among the first of its kind to directly address the supply of healthcare professions [8,16].

The initial focus of the federal government was to direct funding support to educational programs for training "new health professionals" and encourage their incorporation into the health system [16]. Early policy initiatives were included in the Allied Health Professions Personnel Act of 1966 and the Health Manpower Act of 1968 (Public Law 90–490). An available group of ex-military medical corpsmen willing to enter the civilian health sector hastened the inception of the PA concept into medical practice. The level of public financial support and attention given to the creation of "new health practitioners" nurtured a diversity of approaches to the training of PAs. The Comprehensive Health Manpower Act of 1971 (Public Law 92–157) was the first large provision of federal dollars for the support of eight health professions schools, and specifically for the creation of PA educational programs along with the expansion of allopathic and osteopathic medical school capacity [18,19].

The Comprehensive Health Manpower Training Act called for the Bureau of Health Manpower (BHM) to provide support for educational programs for PAs and other 'nonphysician' clinicians. This act established an education grants program administered by the BHM under the Health Resources Administration of the Department of Health, Education, and Welfare (retitled the Department of Health and Human Services in 1979) mandated by Section 774a of the Public Health Service Act as Public Law 93–157.

The BHM established an Office of Special Programs to coordinate physician assistant educational program funding activities. Between 1972 and 1975, the BHM Office funded \$11.7 million to train 280 MEDEX physician assistants and 376 Primex providers [21]. Later, the Health Professions Educational Assistance Act of 1976 (Public Law 94–484) was amended by the Health Services Extension Act (Public Law 95–83) to provide grants and contracts for PA and APRN training programs [22]. This began a more than 45 year history of inclusion in PHS Title VII funding for PA education through the *Physician Assistant Training in Primary Care* grant program, first based in the Division of Medicine, then the Division of Primary Care, and most recently back in the Division of Medicine in the Bureau of Health Professions of the Health Services and Resources Administration [23].

Title VII of the Public Health Service (PHS) Act is the only continuing federal funding of PA educational programs as of 2020. PA education grants subsidized through the Primary Care Training & Enhancement Program (PCTE) were successful in training new PAs. For instance, the PCTE program supported the education of 4390 PA students in the 2014–2015 school year (up from 4071 in 2013–2014). Of those students, 29% were minorities and/or from disadvantaged backgrounds, and 13% were from rural areas. Fifty-eight percent of the institutions which were awarded grants through this program were focused on primary care, and the majority of them were in rural or medically underserved areas [19]. These statistics show that the PCTE program is achieving the intended purposes: encouraging students from under-represented groups to attend PA school and increasing PA practice in rural and medically underserved areas. However, this support also helps PA programs expand opportunities for clinical rotations in rural and medically underserved areas. The PCTE also benefits local communities that would otherwise have limited access to healthcare providers. It is common for new PAs to remain in the area in which they completed their education [19]. A review of PA graduates from 1990 to 2009 showed that PAs who graduated from programs supported by Title VII were 47% more likely to work in rural health clinics than graduates of other programs [20].

The Government Accountability Office (GAO) is a federal agency that measures the impact of various pieces of health policy legislation. GAO notes that the Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services (HHS), spent about \$2.7 billion to fund the more than 40 health professions education programs authorized under Title VII and Title VIII of the Public Health Service Act. These programs include those providing grants to institutions, direct assistance to students, and funding for health workforce analyses. GAO has reviewed changes in funding

and in the number of these programs since 1998, along with HRSA's goals and assessment of the programs, and HRSA's national health professions workforce projections. Furthermore, GAO has reviewed relevant laws and agency documents and data, and interviewed HRSA officials and representatives of health professions education associations. Following the assessment, HRSA agreed with GAO's conclusion that updated workforce supply and demand projections are vital for informed decision making about health professions programs [8].

Funding for Title VII and Title VIII programs increased from about \$300 million in fiscal year 1999 to \$450 million in fiscal year 2005, and the overall number of these programs also increased since reauthorization in 1998. From fiscal years 1999 through 2005, funding for Title VII programs rose by about one-fourth, while that for Title VIII programs more than doubled. The overall numbers of Title VII and Title VIII programs administered by HRSA increased from 46 in fiscal year 1998 to 50 in fiscal year 2004. Regular reassessment of future health workforce supply and demand is key to setting policies as the nation's healthcare needs change [22].

Federal support for PA education in the 1990s was characterized by priorities to recruit students and graduates to primary care fields. Initially this was through funding for faculty development and additional deployment incentives. The Health Professions Educational Assistance Act (PL 94–484) increased the PA supply and provided more physicians and PAs for underserved areas. Requirements included expansion of enrollment and recruitment of disadvantaged individuals. Funding for PA education continued throughout the 1980s. According to the now defunct Congressional Office of Technology Assessment, the federal government spent about \$65 million to train PAs and APRNs, up from \$1 million in fiscal year 1969 to \$21 million in fiscal year 1979 [23].

Political momentum for primary care, and the widespread acceptance by organized medicine and the federal government of the generalist concept of PAs created the climate for PAs to emerge as primary care providers. This federal policy focus formalized federal subsidization of PA training. In these early years of PA development local financial support was tenuous and programs relied heavily on federal funding from Title VII [24].

In 1981, the Graduate Medical Education National Advisory Committee (GMENAC) forecasted that by 1990 there would be a surplus of physicians. Many thought this would mark the end not only of federal support for PA education but would doom the existence of the entire profession. The early 1980s saw federal funding cut in half, a number of programs close, and applications decline. Remarkably, the PA profession survived and entered the nineties poised for a period of remarkable growth and widespread utilization [25]. Clearly the forecast of physician supply exceeding demand was flawed.

The 1992 Health Professions Education Extension Amendment (PL 100–607) and 1998 Health Professions Education Partnership Act (PL 100–607) specified a preference for placement of a high rate of graduates in medically underserved communities (MUCs). The 1992 act was further extended in 1998 and provided a priority for trainees from disadvantaged or underrepresented minority backgrounds. During this time, the number of PA programs grew dramatically from 55 in 1990 to 115 in 2000 to 254 in 2020 [26,27].

Primary care training grants no longer are aimed at general support for PA academic programs. At the same time, PA programs have found it increasingly difficult to meet federal targets for the award of funds. For example, meeting grant program requirements for recruitment, retention, and graduation of individuals from underrepresented minority and disadvantaged backgrounds. This intent was reflected in the contract process, which required each PA program to emphasize the following three major objectives in its demonstration:

- training graduates for delivery of primary care in ambulatory settings,
- placing graduates in medically underserved areas,
- recruiting residents of medically underserved areas, minority groups, and women as students.

The Patient Protection and Affordable Care Act (ACA) of 2010 created the Expansion of Physician Assistant Training (EPAT) grants with the goal

of increasing the number of PAs entering primary care. Recipients of HRSA EPAT funding practiced in primary care specialties at a rate 2.5 times higher than the national PA average immediately following graduation and this specialty choice was durable for several years post-graduation. The EPAT program funded 140 PA graduates who immediately practiced in federally designated medically underserved areas (MUAs). EPAT funding supported a more racially and ethnically diverse student population and a higher number of students coming from a rural area than the national average of PA students [28].

#### 4.2. Payment for services

Medicare coverage of medical services provided by PAs was first authorized in 1977 through the Rural Health Clinic Act. The PA profession was approximately 10 years old and numbered about 4000 graduates. Initial PA practice laws required the supervising physician to be the PA's employer. As a result, the Medicare statute stipulated that reimbursement for the medical care provided by PAs be made to the PA's employer. As the need for providers and the understanding of the PA profession expanded, Medicare coverage of medical care provided by PAs was increased to include services in Medicare-certified health maintenance organizations (1982); services provided in skilled nursing facilities, hospitals, and assisting at surgery (1986); and services provided in rural health manpower shortage areas (1987). In 1997, Congress authorized coverage of services provided by PAs, as allowed by state law in all settings and at a uniform rate. As of 2020 the policy of "incident to" billing remains in place although the recommendation by MedPAC in 2019 called for its elimination [29]. This reimbursement discount for PA/APRN services applies to the office or clinic setting (not in a hospital). Essentially CMS requires that the physician be part of the patient encounter during the initial visit for the medical condition, establish a diagnosis and treatment plan, and be on-site when a PA or APRN renders a follow-up service. The GAO reviewed the progress made by the DHHS to implement the Rural Health Clinic Services Act, the extent to which Medicare beneficiaries use the clinics. The finding was that the Act had not been fulfilled and obstacles prevented broader implementation of the Act. Amendments followed.

#### 4.3. Other federal enactments

Federal initiatives that were not acts but significant policies include the commissioning of PAs as medical officers in the Departments of Defense, Health and Human Services, and Homeland Security. With commissioned officer status of PAs in the US Public Health Service (USPHS) and uniformed military services (Army, Navy, Air Force, Coast Guard) along with the Reserves, Army National Guard, and Air Guard, the visibility of the PA became prominent [32,33]. Two USPHS PAs became Admirals raising the visibility of flag rank status for uniformed PAs [31]. The growth of PAs in federal service also brought to light that the federal government was the largest employer of PAs [30].

#### 4.4. The effect of the SARS-CoVid-2 crisis on states

During the SARS-CoVid-2 crisis, some US states modified legislation and streamlined statutory language relating to PA practice allowing improved care to patients without restrictive supervisory barriers. An example was where the governor removed language stating that a PA is the agent of the supervising physician. While the effect of state enabling legislation on PA employment and development is beyond the scope of this public policy analysis, the stage is set for a complement report on the influence of state and territorial legislation that grew in parallel to national policy efforts.

## 5. Summary

In summary, the role of government, particularly in relation to domestic social programs, has stimulated or supported the private sector. This has been the case particularly in the area of health provision where

considerable federal and state resources have been used to influence private sector activities including medical services delivery. The establishment of Title VII and Title VIII has been a noble effort of the federal government to address problems in medical services delivery [32]. Title VII support for PA educational programs produced the intended outcome – primary care providers who have been shown to care for rural and medically underserved populations. A study using data from the National Ambulatory Medical Care Survey data (1997–2003), found that poorer patients are more likely to see PAs than physicians in outpatient clinics and patients in rural areas were more likely to visit PAs as compared to patients in urban areas [34].

### 5.1. Limitations

Missing from this federal analysis is the influence of professional organizations such as the American Academy of Physician Assistants, the Physician Assistant Education Association, the National Commission on the Certification of Physician Assistants, and the Accreditation Review Commission on the Education of the Physician Assistant. Their influence in the passage of acts and initiatives cannot be underestimated. At the same time, the experience of the individual states in passing enabling legislation for PA practice mounted an effect that no doubt influenced congressional representation from those states. State-based PA policy is beyond the scope of this policy analysis and a complementary policy evaluation is needed.

## 6. Conclusions

The contemporary physician assistant profession is a byproduct of federal activism in the public health sector. PAs were created through a series of national policies followed by state regulation and as a result have emerged as a key player in health delivery in the United States. Original aims of improving access to care, extending physician services, and strengthening primary care have been attained. The birth of the PA began on the eve of the White House Conference on Health which coincided with the 1965 passage of the Medicare and Medicaid programs and Community Health Centers. Half a century later, PAs are firmly established in US medicine in all manner of clinical settings and specialties. The policies that gave impetus to this novel health workforce experience were evolutionary and innovative. The result reveals a manifestation of healthcare reform that continues well into the 21st century. From 1966 to 2024 (58 years) there have been a series of significant federal acts, policies, and improvements that enable PAs to provide medical services in American society. The theory is that a nation that has limited human resources for healthcare will create a physician analog that will be federally sanctioned through piecemeal legislation until its success is assured.

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