VIEWPOINT

ON HEALTH PROFESSIONS REGULATION

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Strengthening the Links between the Public Health Community and Health Professions Regulation

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LICENSURE OF HEALTH PROFESSIONALS IS A BUREAUCRATIC behemoth made of up 50 different state systems, each with its own dozens of agencies, departments, divisions, boards, and committees. The current system is the product of legislative and political battles well financed by professional associations. Though far from a sexy media topic, licensing policies hold the key to the number of practitioners available in underserved areas, and licensing regulations set the minimum levels of competence for safe health care delivery; endeavor to prevent substandard care; and mandate sanctions for incompetent providers.

The web of statutes, rules, and regulations that control the practice and provision of health care is intimately grounded in protecting the public. In many ways, licensure serves to promote and enhance the public health mission, specifically the essential public health services of *enforcing laws and regulations that protect health and ensure safety*; *linking people to needed personal health services*; and *assuring a competent public health and personal health care workforce*.[1]

Why then has professional licensure traditionally not been the concern of state and federal public health agencies? Why have policy makers largely ignored the calls from public health leaders[2] and the Institute of Medicine[3] for state public health departments to regulate health care professionals? Why have public health professionals failed to see what implications licensure holds for health care access and quality? And why, at a time when policy analysts have exposed the shortcomings of regulatory systems, have public health professionals not been at the forefront of reform efforts?

In what follows, we illuminate the regulatory infrastructure and its shortcomings, highlight recent policy developments, and suggest that public health agencies and leaders can and should play a pivotal role in improving a system that is no longer protecting the public's health as intended.

WHAT IS WRONG WITH THE CURRENT REGULATORY SYSTEM?

With its 1998 report,[4] the Pew Health Professions Commission joined a long line of critics and analysts calling for an overhaul of the system we use to regulate the health care professions.[5–14] The Commission, a national, nonpartisan panel of experts, points out that professional licensure has in several fundamental ways failed to meet its mandate to protect the public.

The Pew Commission believes that state-based health care workforce regulation will best serve the public by:

- Promoting effective health outcomes and protecting the public from harm;
- Holding regulatory bodies accountable to the public;
- Respecting consumers' rights to choose their health care providers from a range of safe options;
- Encouraging a flexible, rational and cost-effective health care system which allows effective working relationships among health care providers; and
- Facilitating professional and geographic mobility of competent providers.[4]

A competent licensed workforce to provide high quality health care demands a licensing system that is designed to serve the public good. No one denies that the regulatory system has set useful educational criteria for new professionals and mechanisms to remove the most egregious practitioners from patient care. However, the evolution of professional licensure—in a manner that serves professional interests first—has also put many statutes, rules, and regulations at cross purposes with licensure's broader public protection mission. This has resulted in limited public accountability (few boards are forthcoming with the information they have about practitioners), support for practice monopolies that limit access to care (established professions work hard to keep new and emerging professions from encroaching on their domains), and professional practice laws that vary unnecessarily from state to state. The two priority areas that hold the most challenges to, and promise for, improving professional regulation are scope of practice authority and the composition and responsibilities of regulatory boards.

Scope of practice authority. The three goals of an optimal health care delivery system are universal access, lowest possible costs, and highest possible quality. Improving the processes with which we determine professional scopes of practice authority holds the potential for significantly improving access to care, particularly for underserved populations.

The legal authority to provide and be paid for health care services originates in state statutes generally referred to as practice acts, which establish professional "scopes of practice." These practice acts spell out what each profession can and cannot do. The high stakes associated with practice acts include regulatory authority over the profession and providers' authority to bill third-party payers for services. Efforts to change practice acts usually end up with "turf battles" between the professions fought out in state legislatures. Examples include battles between nurse anesthetists and anesthesiologists, advanced practice nurses and physicians, and dental hygienists and dentists.

State legislators, rarely trained as health professionals themselves, spend considerable amounts of time deciding whether new or unregulated disciplines should be regulated and whether professions currently regulated should be granted expanded practice authority. For the professions, turf battles are not only time-consuming but also expensive. Although professional associations are not forthcoming about the costs involved, many have hired lobbyists and staffed legislative departments to protect or expand their perceived interests. The American Medical Association has formed a comprehensive high technology Advocacy Resource Center as part of an advocacy campaign that is perceived at least in part by officials of state medical societies and specialty groups as help to defeat "onerous" legislation sought by non-physicians.[15] Campaign contributions are another expensive item on the tab of professional associations. For example, a four-year dispute in California between ophthalmologists and optometrists over who could treat certain eye diseases with what medications reportedly cost more than $1.8 million in campaign contributions to state legislators alone.[16]

More important, the decision-making process can be distorted by these campaign contributions, lobbying efforts, and political power struggles. Decisions about which professions can provide what services safely should be based on comprehensive evidence regarding the accessibility, quality, and cost-effectiveness of care provided to the consumer. However, the evidence supporting expanding or overlapping scopes of practice can be drowned out by the efforts of well-established and well-financed professions seeking to limit the efforts of evolving professions. As a result, the majority of legislation that would expand scopes of practice is not enacted.[17,18] Legislation that is enacted is often limited, incremental in nature, and idiosyncratic, varying from state to state for a single profession.

Decisions made in this environment, in which evidence regarding quality of care and potential impact on

health care costs and access does not come into play, may not be in the public's best interest. For example, there are thousands of federally and state-designated health manpower shortage areas across the country today. Any state that does not permit professionals such as nurse anesthetists, advanced practice nurses, and dental hygienists to practice to the full extent of their competence—as evidenced by their education and in many cases practice experience in other states with less restrictive statutes—is unnecessarily limiting the public's health care options.

Composition and responsibilities of regulatory boards. With few exceptions, health care professionals are regulated on a state-by-state, profession-by-profession basis. An individual board in each state for each of dozens of professions, composed largely of members from that profession, is charged with policing licensees. The regulatory authority for more than a hundred additional professions often lies in the hands of these boards. Typically, medical boards regulate physician assistants, nursing boards regulate nurse-midwives, and dental boards regulate dental hygienists. But for many professions, the regulatory seat of power is less predictable. For example, depending on the state, direct-entry midwives might be regulated by their own board, a board of medicine, a board of nursing, or an umbrella state health or occupational licensing agency.

The efforts of isolated and independent boards are rarely coordinated within a state, creating different and thus confusing complaint and discipline processes for the various professions and a challenge to ensuring public safety. Variations between states, combined with the shortcomings of the National Practitioner Data Bank, a registry of disciplinary actions taken by state licensing boards and hospitals against practitioners (including its coverage of just a couple of professions and limited access to its data), can result in inadequate systems for tracking incompetent practitioners seeking to flee a bad record in one state by moving to another. Variations in licensing requirements also limit the mobility of competent professionals seeking to relocate or practice across state lines. These problems have only been exacerbated by technological changes (for example, with "telemedicine," the provider of care need not be at the same location as the patient) and by marketplace changes (for example, health plans and managed care organizations are often interstate enterprises).

Although charged with consumer protection and despite open meeting laws, boards and their processes are generally unknown to the public. Strong consumer representation is not often seen on these boards, thus perpetuating images of self-serving professionals. In addition, in an era in which information about professionals' education and practice histories is crucial to public safety and informed consumer choice in a competitive health care market, boards are insufficiently equipped and financed to collect, manage, and publish information that would be useful to the public.

WHERE DOES THE PUBLIC HEALTH COMMUNITY FIT IN?

Public health agencies, leaders, and professionals are part of this flawed system at two junctures: the regulated and the regulators. Clinicians and care providers employed by departments of public health—including physicians, nurses, emergency medical technicians, and so on—must be licensed (or otherwise credentialed) by the state. Tens of thousands of state-regulated health professionals are employed by public health departments that own and operate facilities such as public hospitals and clinics.

Public health professionals may function as regulators as well. In some states, public health agencies play limited oversight roles. For example, unlike in most states, where health professions regulation falls under agencies such as the Department of Consumer Affairs or a central occupational licensing department, in Washington State, the Department of Health is *the* agency for health professions regulation. Since 1983, it has regulated "new" professions (including dietitians, naturopathic physicians, and acupuncturists) directly; for the professions that were regulated prior to 1983 (such as medicine, nursing, dentistry, chiropractic, and optometry), the Department uses boards, commissions, and committees in various capacities. Louisiana's Department of Health and Hospitals reviews the budgets of licensing boards for compliance with all accounting, reporting, auditing, and review requirements and is responsible for review of procurement, contract management, and fees. However, the state's two dozen boards have sole responsibility for the regulation, examination, certification, and licensing of professionals and enforcement of the practice acts for their professions.[19]

In several other states, departments of public health directly regulate a limited number of health care professions (such as emergency medical technicians or massage therapists). In most states however, despite the mandate to *enforce laws and regulations that protect health and ensure safety*,[1] public health agencies are charged with little or no responsibility for regulating health care professionals.

The public health community can bring to the debate on health professions regulation perspective and expertise on how to protect the public.

Public health agencies and professionals are facing a time of redefinition, and ongoing debates center around their roles and responsibilities.[20,21] Discussions to date, however, have largely ignored the professional regulatory arena despite the roles public health agencies do and could play.

What Can Be Done for a Better Future?

The Pew Health Professions Commission has taken the lead in describing the five elements of a regulatory system that truly responds to the needs of the public.[4] In what follows, we discuss the role public health professionals and policy makers can and should play with regard to each of these elements.

1. A move toward national standards. To mirror shifts toward uniformity in educational and practice guidelines for the health professions at the national level, health care workforce regulation needs to move in the direction of national scope-of-practice standards for each profession. As noted above, scopes of practice are currently decided on a state-by-state basis in legislatures, in a process that is not guided solely by empirical evidence. As a result, practice acts can vary, often significantly, from state to state. A person living in a state that has a powerful professional association intent on keeping an emerging profession from practicing will face more limited choices of health care providers than her neighbor across the state line.

In addition to the ever-increasing interstate mobility of the population, one of the major drivers of the move toward national standards is telemedicine/telehealth (with which consumers in one state can receive virtual health care from a professional in another state, where the relevant statutes and regulations may be different).

Seeking to avoid federal intervention and increasingly frustrated with legislative challenges to practice acts, state policy makers are looking for ways to merge the benefits of uniform practice acts with the states' responsibility to protect the public.

The field of public health, with its focus on the health of whole communities and populations, is well positioned to facilitate the move toward safe national standards for the professions. Public health professionals are well aware that state political boundaries are less predictive of differences in disease burden and health status than factors such as intrastate geographic location, socioeconomic status, gender, race, and ethnicity. In addition, public health infrastructures are in place at the national, state, and local levels for information sharing, research, and standards development and enforcement. These capacities, with coordination between federal and state agencies, could be engaged to improve state-based consumer protection. For example, public health planners and policy makers could take the lead in capturing practice and outcome data at the state level to inform evidence-based national standards and in developing best ways to implement national standards at the state level.

2. Significant overlap of practice authority among the health professions. Traditional boundaries—in the form of legal scopes of practice—between the professions have blurred. This evolution has been driven largely by the non-physician professions seeking expanded practice authority and innovation in the workplace (including the employment of cross-trained, multiskilled workers), but the legal scopes of practice still lag behind what is actually happening in professional education and practice. This trend toward overlapping practice authority will continue to pressure the regulatory system to evolve. The current system, in which tradition, campaign contributions, and lobbying efforts may outweigh the best evidence, must better accommodate the demand for flexibility while ensuring that the public's safety is protected.

However, the research capacity of public health professionals and agencies has not yet been fully tapped. In the future, the evidence used in developing and amending practice acts should be drawn not only from the clinical expertise of health care practitioners but also from epidemiological expertise in arenas such as population and community health. In addition, the public health

community could support the design and implementation of valid demonstration projects that would safely allow the professions to test their members' competence to provide services outside their traditional scopes of practice. Currently, many professions are stuck in the bind of not being permitted to expand their scopes of practice because they do not have the data to back up their requests for expanded roles, while they cannot collect the data without violating their practice acts. Policy makers could use the data collected from methodologically sound demonstrations to write uniform, evidence-based practice acts for each profession.

3. New venues and participants for regulatory policy-making. The representation of various parties at health care decision-making tables needs to change in response to new consumer demands. For example, legislatures may not be the best venue in which to decide technical professional matters (such as professional scopes of practice) because lobbying, campaign contributions, and allegiance to constituents often distort rational policy development. A more impartial venue in which all interested parties, particularly consumers of health care services, are represented will better support regulatory policy-making that is accountable, balanced, and based on empirical evidence.

In some states, public health agencies are playing strong roles in efforts to improve the decision-making process regarding overlapping practice authority. For example, the Iowa Department of Public Health administers the recently authorized scope of practice review committees. These committees, composed of non-legislators, are convened as needed to make recommendations for resolving specific scope of practice conflicts.[22]

Despite considerable knowledge about the health care needs of the public, public health agencies are rarely at the table when decisions about scopes of practice are made. Public health agencies could assist with the development and testing of new mechanisms (such as the Iowa review committees) for deciding practice parameters. Working in tandem with academic institutions, public health agencies could collect and weigh evidence about competence, cost, quality, and access to care. In addition, representatives of public health agencies, as they do in other arenas such as environmental health, could serve as technical advisors to state legislatures.

4. Integration of regulatory systems that protect health care consumers. Efforts to regulate health care organizations, care delivery sites, and health care professionals historically have been independent endeavors, both within and across states. Market trends to integrate delivery systems and providers are challenging our century-old, balkanized systems for regulation. The compartmentalized approach to regulation produces costly redundancies when two or more systems require the same data from individuals and institutions.

This lack of coordination and integration among systems has also resulted in inefficiencies and inadequate protection of the public. As noted above, lack of coordination of licensing requirements limits practitioners who could otherwise competently provide care across state borders. On the other hand, lack of coordination of complaint and disciplinary procedures between hospitals, health care organizations, and professional licensing bodies can allow incompetent practitioners to move more easily from health plan to health plan and from state to state.

One of the strengths of a public health perspective is its comprehensiveness. Public health institutions and disciplines develop and provide "public goods" ranging from care to the uninsured to programs in environmental protection, health promotion, and disease prevention. Furthermore, public health professionals work to understand and act on the interrelationships among these areas as well as their relationships with biomedical science and medicine.[21]

With this comprehensive perspective, state and national public health agency links to professional licensure provide leverage points for better coordination of public protection law and policy. State departments of public health, whether charged with oversight responsibilities or with direct regulation of individual professions, can lead efforts to better understand and rationalize complementary policies and agency roles. At the federal level, the Bureau of Health Professions (within the US Public Health Service), manages the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). While the HIPDB has yet to be fully implemented and tested, the NPDB has a history of covering only a couple of the health care professions and has been of limited use to state regulatory boards, much less to the public, who do not have access to NPDB data. Better links between the NPDB, state licensure boards, and hospitals and health systems could dramatically improve efforts to protect consumers from incompetent practitioners.

5. Increased regulatory focus on quality of care and assurance of competence. Concerns voiced by

consumer advocates and elected officials over market forces in health care illuminate the need to strengthen consumer protection. The integration of regulatory entities and increased consumer participation in policymaking called for above will contribute to regulations that emphasize quality assurance and cooperation among the professions.

Public health professionals have long played a critical role in health policy development in the areas of public protection and quality assurance. Traditionally, these efforts have focused on such domains as water and air quality, occupational safety, the "safety net" clinical infrastructure, and health services and policy research. These contributions could be expanded to provide additional empirical evidence regarding licensure's link to professional competence and quality of care. Although it has long been assumed and argued that licensure protects consumers, the evidence is ambiguous about its effect on quality of care. Some public health agencies are testing that assumption. For example, Washington's Department of Health is exploring whether and how the state's health care professionals should demonstrate continued competence throughout their careers, which would strengthen the link between relicensure and quality assurance.

In addition, studies of the effects of changes in licensure policies on health care access and utilization could reveal innovative ways in which the health care workforce could be employed to better serve the public interest.

CONCLUSION

Some state departments of public health are charged with direct, if limited, responsibilities in regulating the healthcare workforce. Public health professionals and agencies have a role in enforcing the laws and policies that protect consumers; even when not specifically charged with authority to regulate, the public health community can bring to the debate on health professions regulation perspective and expertise on how to protect the public. In particular, the public health perspective can serve as a valuable counterforce to the "turfism" that guides health professions regulation. Public health professionals can provide a valuable impetus for reform by reminding legislators that the major purpose of such regulation is protection of the public, not the professions. This is a legitimate and important public health function and a banner that professionals in the field should carry. Few others seem willing to do so.

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