HEALTH LICENSING BOARDS AND GOVERNANCE STRUCTURE

Prepared for the **Minnesota Health Licensing Boards**

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Preface

This report was prepared by Anna Bonelli, Research Analyst, for the following Minnesota Health Licensing Boards.

Minnesota Statutes: Authority for Board	Board
148.02	Chiropractic Examiners
150A.02	Dentistry
148.622	Dietetics and Nutrition Practice
144E	Emergency Medical Services Regulatory Board
148B.30	Marriage and Family Therapy
147.01	Medical Practice
148.181	Nursing
144A.19	Nursing Home Administrators
148.52	Optometry
151.02	Pharmacy
148.67	Physical Therapy
153.02	Podiatric Medicine
148.88	Psychology
148B.19	Social Work
156.01	Veterinary Medicine

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Purpose

The critical question addressed by this study is, "What type of governance structure makes for the most effective boards?" The purpose of this report is threefold:

1. Explore and clarify models of professional regulation;
2. Define what it means for regulating bodies to be "effective";
3. Describe models of occupational regulation in terms of the criteria for effectiveness.

This study examines the governance structures of several states across a continuum of independent boards (boards that are not attached to a larger agency and have control over staffing and licensing and disciplinary activities) to boards that are more consolidated (boards that are located in a larger, umbrella organization and share staff with other boards).

Project

This paper addresses the effectiveness of health licensing boards' governance structure across the United States in three parts. The first part synthesizes literature and interviews with experts. The second part develops a framework for evaluating governance structure based on governance features and criteria for effectiveness. Last, this paper examines the health credentialing governance structures of eight states and one Canadian province: five states represent the continuum of governance structure from independent boards to boards located in umbrella agencies (consolidated); three states and one province are explored for their interesting governance features which include an oversight or collaborative council or committee.

To develop findings, this researcher first conducted a review of the literature and sought the insight of experts in the field of professional regulation. Then, a framework for evaluating effectiveness was developed. Next, regulators and other interested parties were interviewed in each of the states selected for case study.

The findings are limited by the availability of data to adequately measure effectiveness, the inability of the scope of the project to account for all variables associated with effectiveness, and the fact that case studies are inherently unsuitable for drawing conclusions about other states.

Key Findings

The following findings synthesize results of the eight states and one province examined for case study, interviewees' responses and consultation with experts and literature. The findings generally support some of the Minnesota Legislative Auditor's 1999 findings: "We found no convincing evidence that any particular organizational arrangement or process provides an assured solution to any given problem associated with occupational regulation."[1]

1. Research examining governance models for professional regulatory boards indicates no consensus on the topic. A review of dozens of previous studies uncovered little quantitative research on licensing board models. This ambiguity may result from the difficulty in isolating

governance variables, or because governance structure is less important to regulators' mission of public protection than other factors like funding, management or service environment.

2. Most regulators do not perceive a problem with their state's governance structure. When asked how their boards' structure supported public protection, approximately 85 percent of the 70 respondents answered that it supported their mission well. Exceptions included five respondents from consolidated agencies who indicated that some of the larger boards should have an independent board, or that they would like more autonomy.

3. Cooperation among boards is beneficial for regulators. About ten respondents indicated satisfaction with arrangements to save resources or to exchange information among board staff. These relationships include pooling resources such as office space and supplies in Oregon, formal arrangements at the Virginia Board of Health Professions and cooperative meetings in Ontario. One respondent mentioned that being forced to work together under the formal arrangement of the Texas Health Professions Council was beneficial to the boards' staff even though it occasionally was not preferable. Simply sharing office space may help generate shared social capital among boards' staff.[2]

4. Although all eight states and one province contacted for cases study were suffering from fiscal shortfalls, respondents from more autonomous boards were less likely to cite a funding shortage for their boards. These responses may indicate that the financial status of larger, umbrella agencies is tied more closely to the state, even in states that have the authority to raise fees without approval of the legislature. In addition, this may lend support to researchers Graddy and Nichol who theorized that consolidation may not realize the intended fiscal savings or that consolidated agencies may receive less funding.[3]

5. Resolving scope of practice disputes between professions to the benefit of the public is one of the most important issues with which regulatory bodies are involved, and there was no consensus among experts or respondents on the best way to manage these conflicts. Most respondents from Ontario and Virginia felt that having a collective to conduct objective research for sunrise legislation and scope of practice issues was helpful to the process. However, the contentious experience from Iowa is indicative of the powerful role of politics in any situation. Legislatures' deliberations on scope of practice issues can be aided and focused by factual research from an "objective" body, namely, the other health licensing boards or a committee called for that purpose.

6. The research on the three states and one province with special features does not definitively indicate the degree to which oversight boards or councils are useful organizations or instead add another layer of bureaucracy to the regulatory landscape. The literature generally favors oversight structures for research, accountability and ameliorating scope of practice issues, but a minority of respondents from states with oversight structures (excluding Ontario) did not indicate that their board reaped the expected benefits. More research is needed to identify what forms and management techniques may be the most efficacious.

INTRODUCTION

Virtually every state in the U.S. has a different governance structure for regulating health professionals. Debates about the advantages and disadvantages of independent licensing boards versus consolidated boards are numerous but unresolved; there are no commonly recognized set of "best practices" for governance structure. Over the past several decades, the trend has generally moved towards consolidation of functions, staff and resources of previously autonomous boards.

Despite the trends, there are no comprehensive analyses that determine the most effective model. This is likely due to the difficulty in gathering data related to regulatory outcomes, as well as state by state variations that make an "apples to apples" comparison difficult. In addition, states that have reorganized their credentialing bodies usually do not conduct follow up studies.[4] Similarly, the definition of "effectiveness" is elusive; "effectiveness" often means different things to different states and different researchers.

In light of these gaps in the research, the purpose of this report is threefold:

1. Explore and clarify models of professional regulation;
2. Define what it means for regulating bodies to be "effective";
3. Describe models of occupational regulation in terms of the criteria for effectiveness.

The third purpose is the most problematic because of the issues that arise when attempting to understand effectiveness: each state has a different service environment, requirements and regulations, so comparisons are not conclusive.

To address these purposes, this report begins by exploring some of the known research on professional regulation, drawing out the main themes discussed by experts and states across the country. The "Study Approach and Limitations" describes the research framework as well as the limitations of the data and the design. The section Governance Models gives a brief overview of the five standard classifications of governance structures across the 50 states. Next, case studies are compared using criteria for effectiveness, beginning with those states that represent the five standard classifications, followed by four examples of states with distinctive features that may improve effectiveness. The "Key Findings" synthesize information from a review of the research and the case studies, and can be found in the Executive Summary.

RESEARCH REVIEW

A review of the literature turned up little consensus among experts favoring one professional regulation governance structure over another. Few empirical studies have been conducted on the topic.[5] The Minnesota Office of the Legislative Auditor's study of professional regulation in 1999 states:

> In sum, despite the flexibility that our federal system allows, no state we studied appears to have solved the subtle yet chronic problems that accompany occupational regulation…We found no convincing evidence that any particular organizational arrangement or process provides an assured solution to any given problem associated with occupational regulation."[6]

Other experts and researchers make similar statements about the lack of data or applied research that reliably asserts one structure's advantage over another.

- "Extensive research…turned up very little research in this area…There are no recognized national standards or 'best practices' for how states should organize their health care regulatory programs from an overall policy/systems perspective."[7]
- "The expectation that regulatory agencies will alter their performance in response to… structural changes is largely without empirical support."[8]
- "While there are reasonable arguments for and against consolidation, there is little actual research and evidence of the impact of consolidation on occupational regulation."[9]
- "Consolidating board functions is theoretically appealing, but studies are inconclusive about whether protection of the public and efficiency are enhanced."[10]

Often, this lack of certainty results from the fact that although several states have changed their governance structure in the last several decades, "states rarely conduct follow-up studies to determine the results of their re-organization initiatives."[11]

Other experts question whether the governance structure actually has a significant impact on the effectiveness of occupational regulation. Some experts assert that factors such as staffing and funding of board activities may make a greater difference to public protection than boards' degree of autonomy.[12]

Despite the lack of conclusive evidence, many states have moved to consolidate their boards or board functions in the last several decades, motivated by several factors:

- the expectation of cost savings as a result of economies of scale[13]
- the prospect for small occupations to share otherwise redundant administrative inputs[14]
- the opportunity to promote overlapping scopes of practice and share expertise for like occupations[15]
- to encourage standardization of policies among boards

A few states have considered structural changes like consolidation, but rejected the change when they concluded that the advantages listed above could not be realized to the extent thought possible. For example, the Minnesota Office of the Legislative Auditor concluded that because of advances in technology, "the economies available from centralization of [administrative] services have greatly diminished or vanished altogether."[16] In addition, a California Senate

subcommittee on Efficiency and Effectiveness in State Boards and Commissions did not recommend consolidation of the disparate Board of Landscape Architects (BLA) and the Board of Architectural Examiners (BAE) because "merging the BLA with the BAE would not improve the efficiency of the board" largely because the boards were so dissimilar.[17]

Findings from a Review of the Research

Although the literature review and consultation with experts on occupational regulation did not result in consensus, several findings emerge:

- No consensus exists on the most effective board governance structure. There are no universally recognized "best practices," that is, no studies have taken a comprehensive look at evaluating board performance.
- The existing evidence and expert opinions points towards the advantages of independent boards in part because of the inconclusiveness of cost savings from consolidation, and evidence showing that independent boards take somewhat more or about the same number of disciplinary actions.
- Boards' disciplinary actions are discussed frequently because of the sensational qualities and because of the accessibility of data. However, conclusions on the effectiveness of various models in disciplinary matters remain speculative.
- Scope of practice disputes between professions, sometimes playing out in "turf battles," can result in a reduction of access to care for consumers. Although there is some speculation regarding the advantages of a consolidated agency or some type of oversight board in mitigating these disputes, evidence remains scant.
- Public participation and awareness of boards' actions are minimal. The consensus of opinion indicates that centralized access to board information can help to mitigate these concerns for consumers, whereas consumers may be confused by multiple, discreet agencies.
- Politics infuse health licensing boards on many levels, from the initial regulation of professions to changes in the scopes of practice. Boards' structure should attempt to minimize political bias among board members and staff by having clear lines of accountability and efficacious public representation.

For more detail on some of the major discussions of the research, see Appendix B – Research Review.

STUDY APPROACH AND LIMITATIONS

This section outlines the framework of the study to explain how the models of governance structure will be described and evaluated. This section addresses the purpose of the study:

1. Explore and clarify models of professional regulation;
2. Define what it means for regulating bodies to be "effective";
3. Describe models of occupational regulation in terms of the criteria for effectiveness.

To accomplish these goals, first Table 1 lists **Governance Features,** or independent variables, that describe in detail the models of professional regulation. The Governance Features focus on variables that may significantly affect cost and variables that indicate the degree of independence. These are features that may influence boards' criteria for effectiveness, listed below. Table 4 on page 12 presents the Governance Features for five of the states analyzed for case study.

Table 1. Governance Features (Independent Variables)

Independence

- administered within a larger agency
- advisory to another agency/director
- composed of members of the regulated profession and public members
- decisions reviewed by agency/commissioner
- members appointed by the Governor

Administration

- hire its own staff
- appoint an ED/Board Administrator
- answer inquiries from public/licensees
- share staff with other board/agency
- co-locate with other board/agency
- share administrative services with other boards
- contribute portion funding to a shared administrative body
- share space with other board
- conduct rulemaking
- do their own budgeting

Policy-making

- define scope of practice through rulemaking
- sets grounds for discipline through rulemaking
- establish, change policy

Public Education

- send newsletter to licensees
- conduct other regular activities
- complainants are kept informed of the adjudication process

Licensure

- administer exams
- contract for exam services
- process applications for licensure
- administer renewals
- verify credentials for new licensees
- set qualifications for renewals through rulemaking
- set qualifications for sitting for exam through rulemaking

Compliance

- discipline licensees
- receive complaints
- investigate complaints
- have in house legal representation
- use AG as legal representation
- have an appeals process
- address unlicensed practice
- hold hearings

Funding

- collect fees
- set fees
- budget built into another agency
- pay for services to other state agencies (AG, Admin, Finance, etc.)
- funded fully through fees
- receive general funds

Next, Table 2 lists **Criteria for Effectiveness** (dependent variables). These criteria develop a comprehensive picture of what it means for professional regulating bodies to be successful. According to the research design, the Governance Features, listed above, should impact the criteria results for the states under case study. Table 5 on page 15 presents some of the Criteria for Effectiveness for five of the states analyzed for case study.

Table 2. Criteria for Effectiveness (Dependent Variables)

Outcomes: Consumer health is protected from unscrupulous or incompetent practitioners.		**Process**: Boards function efficiently.	
Accountability	**Access**	**Customer Service**	**Compliance**
▪ The public is aware of the boards' role in public safety. ▪ The board can be held accountable for their decisions. ▪ Boards' decisions are subject to oversight (checks and balances). ▪ Consumers are aware of regulatory requirements. ▪ Consumers are aware of how to file a complaint.	▪ Consumers have choices among competent providers across occupations. ▪ People who are competent to practice are not screened out. ▪ Licensure requirements are not discriminatory.	▪ Processing applications is timely. ▪ Processing renewals is timely. ▪ Licensees perceive that staff is courteous. ▪ Licensees receive accurate information. ▪ Licensees and consumers get the information they need easily.	▪ Parties get due process in a timely fashion. ▪ Complainants feel that their complaint was addressed fairly. ▪ Consumers find complaint process to be user-friendly. ▪ Regulatory body manages complaint process consistently. ▪ Complainants are informed of the adjudication process. ▪ The complaint process is adequately funded.
Scope of Practice	**Other**	**Financing**	**Other**
▪ Scope of practice is appropriate for each profession. ▪ Disputes between professions are resolved to the benefit of the public.	▪ Practitioners are aware of regulatory requirements. ▪ The public feels they are protected. ▪ Degree of disciplinary action is appropriate to the infraction. ▪ Number of disciplinary actions represents violations.	▪ Funding is enough to support effective management. ▪ Administrative inputs are not duplicative.	▪ Staff have the appropriate skills to be effective. ▪ Board members are qualified and capable of performing their duties. ▪ Different professions are treated consistently. ▪ Outside influences do not exert significant pressure on regulatory decision-making.

The Criteria for Effectiveness emerged from research describing health licensing boards' mission as well as the advantages and disadvantages of various models.[18] The criteria are divided between the two goals of process and outcomes. The criteria listed under "outcomes" account for the end result of the boards' efforts. Outcomes include criteria that describe the degree to

which the overall mission of the boards is fulfilled. The criteria listed under "process" account for inputs and the manner in which services are delivered. Both outcome and process criteria contribute to "effectiveness" because both are important to the proper functioning of boards. Although public protection is the mission of regulation, as public entities, health credentialing entities have a responsibility to taxpayers to perform their work efficiently. Also, as organizations that often operate on the fees paid by licensees, boards are obligated to strive for good customer service.

Study Limitations

The framework described above represents an attempt to comprehensively describe and evaluate boards' governance structures. However, the critical question ("What type of governance structure makes for the most effective boards?") will not be answered definitively because of the limitations of the data.

The first limitation is the availability of data to adequately measure effectiveness. In order to judge completely the effectiveness of a board, all of the criteria in Table 2 should be addressed. However, no data is available to understand some criteria; in particular, data that describes the outcomes of professional licensing agencies are limited. In lieu of statistical data representing these criteria, the research design dictated that data be gathered through interviews with parties who may be able to shed light on some of the otherwise unobtainable information. However, this approach is less systematic than had regularly collected performance measures or indicators been available. The data collected represents a limited portion of the possible means of evaluating health licensing boards.

Another limitation to the study is inherent in the case study method, used to explore and evaluate the eight states and one Canadian province. Case studies are not designed to result in data that can be used to extrapolate conclusions about other organizations easily. Although the project was designed to generate "cause and effect" (independent and dependent) variables, caution should be taken in drawing conclusions about other states outside the case studies. Rather, case studies are helpful for finding "best practices" of individual states.

A final limitation of the study is the fact that it is impossible to isolate the variables related to boards' structure in order to test the effects of the Governance Features on the Criteria for Effectiveness. Dozens of factors could influence the outcome and process criteria such as:

- service environment (cost of living, salaries, urban versus rural areas, income levels, environmental influences)
- budget and staffing levels of the agency or board
- varying licensure requirements
- public education activities
- intensity of consumer-advocates' or professional-advocates' involvement in the credentialing process
- management expertise, drive and productivity
- the political climate

GOVERNANCE MODELS

This section addresses the first purpose of the study:

1. Explore and clarify models of professional regulation;

Each state in the nation has a somewhat different model of governance for health licensing entities. Models range from boards that act as independent state agencies and share few or no services, to those with boards that advise a director or professional regulator on licensing and disciplinary matters.

The following descriptions of models occupational licensing bodies in the 50 states are taken from the works of Benjamin Shimberg, a long-time expert in the field of professional regulation.[19]

> **Model A**. Boards hire their own staff, make decisions about office location, purchasing, and procedures. Each board receives and investigates complaints and disciplines licensees. Each board is responsible for the preparation, conduct, and grading of examinations or the contracting out of these tasks. Each board sets qualifications for licensing and standards for practice. Boards collect fees and maintain financial records. Board staff prepares and mails applications for licensing and renewal, and answers inquiries from licensees and the public.
>
> **Model B.** Boards are autonomous, but less so than in Model A. They set policy and determine standards regarding licensing and professional practice. They prepare or approve exams and decide who is qualified for licensing and professional practice. They prepare or approve exams and decide who is qualified for licensing and professional practice. They prepare or approve exams and decide who is qualified for licensure. They handle complaints and discipline licensees. The board has responsibility for hiring and supervising its staff. A central agency may be responsible for such housekeeping matters as providing space, answering routine inquiries, collecting fees and licenses and renewals.
>
> **Model C.** Boards are autonomous and have decision making authority in many areas. The central agency, however, has greater authority over certain functions than in Model B. Its powers go beyond housekeeping. For example, board budgets, personnel and records may be subject to some control by the agency. Complaints, investigations and adjudicatory hearings may be handled by a central staff, even when boards continue to make final decisions with respect to disciplinary actions.
>
> **Model D.** Boards are not fully autonomous; that is, they do not have final decision-making authority on all substantive matters as do boards in the preceding models. While the central agency provides a wide range of services, in practice, boards may be delegated responsibility for such functions as preparing exams, setting pass/fail points, recommending professional standards, and recommending disciplinary sanctions. A crucial distinction, however, between Model D and the

preceding models is that certain board actions are subject to review by the central agency.

Model E. The regulatory system is run by an agency director, commission or council, with or without the assistance of a board. Where boards do exist, they are strictly advisory. The agency director, commission or council has final decision making authority on all substantive matters. Boards may be delegated such functions as preparing or approving exams, setting pass/fail points, recommending professional standards, and recommending disciplinary sanctions. A crucial distinction between this model and Model D is that, when boards exist, they serve only in an advisory capacity.

The following table lists the *predominant* model of each state. The manner in which some states function may differ from what is implied by statute.

Table 3. State Models [20]

Alphabetical by state			**Alphabetical by model**	
AK	C Shared Authority		AL	A Autonomous Boards
AL	A Autonomous Boards		AR	A Autonomous Boards
AR	A Autonomous Boards		IA	A Autonomous Boards
AZ	B Shared Administrative Functions		KS	A Autonomous Boards
CA	C Shared Authority		KY	A Autonomous Boards
CO	C Shared Authority		LA	A Autonomous Boards
CT	D Limited Board Authority		MS	A Autonomous Boards
DE	C Shared Authority		NC	A Autonomous Boards
FL	D Limited Board Authority		ND	A Autonomous Boards
GA	C Shared Authority		NH	A Autonomous Boards
HI	C Shared Authority		NM	A Autonomous Boards
IA	A Autonomous Boards		NV	A Autonomous Boards
ID	C Shared Authority		OH	A Autonomous Boards
IL	E Centralized Licensing Authority		OR	A Autonomous Boards
IN	C Shared Authority		SC	A Autonomous Boards
KS	A Autonomous Boards		SD	A Autonomous Boards
KY	A Autonomous Boards		WV	A Autonomous Boards
LA	A Autonomous Boards		AZ	B Shared Administrative Functions
MA	D Limited Board Authority		MN*	B Shared Administrative Functions
MD	C Shared Authority		OK	B Shared Administrative Functions
ME	C Shared Authority		AK	C Shared Authority
MI	D Limited Board Authority		CA	C Shared Authority
MN*	B Shared Administrative Functions		CO	C Shared Authority
MO	C Shared Authority		DE	C Shared Authority
MS	A Autonomous Boards		GA	C Shared Authority
MT	C Shared Authority		HI	C Shared Authority
NC	A Autonomous Boards		ID	C Shared Authority
ND	A Autonomous Boards		IN	C Shared Authority
NE	E Centralized Licensing Authority		MD	C Shared Authority
NH	A Autonomous Boards		ME	C Shared Authority

NJ	C Shared Authority
NM	A Autonomous Boards
NV	A Autonomous Boards
NY	E Centralized Licensing Authority
OH	A Autonomous Boards
OK	B Shared Administrative Functions
OR	A Autonomous Boards
PA	C Shared Authority
RI	C Shared Authority
SC	A Autonomous Boards
SD	A Autonomous Boards
TN	C Shared Authority
TX	C Shared Authority
UT	D Limited Board Authority
VA	C Shared Authority
VT	C Shared Authority
WA	D Limited Board Authority
WI	C Shared Authority
WV	A Autonomous Boards
WY	C Shared Authority

MO	C Shared Authority
MT	C Shared Authority
NJ	C Shared Authority
PA	C Shared Authority
RI	C Shared Authority
TN	C Shared Authority
TX	C Shared Authority
VA	C Shared Authority
VT	C Shared Authority
WI	C Shared Authority
WY	C Shared Authority
CT	D Limited Board Authority
FL	D Limited Board Authority
MA	D Limited Board Authority
MI	D Limited Board Authority
UT	D Limited Board Authority
WA	D Limited Board Authority
IL	E Centralized Licensing Authority
NE	E Centralized Licensing Authority
NY	E Centralized Licensing Authority

*Shimberg lists Minnesota as having "Shared Administrative Functions," but this description oversimplifies the complicated framework, just as any classification system must. Minnesota's Health Related Licensing Boards operate more like "A Autonomous Boards." The Minnesota Department of Health's regulation of some health professionals represents Model E.

CASE STUDIES

This section addresses the first purpose of the study:

1. Explore and clarify models of professional regulation;

Eight states and one Canadian province were selected for in-depth study based on several criteria. Five of the states (Oregon, Arizona, Wisconsin, Michigan and Illinois) represent the five different models of governance. The table below compares the five states' governance features. Following the table is an analysis comparing the states' in terms of the criteria for effectiveness (see Table 2. Criteria for Effectiveness (Dependent Variables) page 7). A narrative description of the states' governance structures can be found in Appendix C – Detailed Case Studies.

Comparison of the Model Representatives

The discussion above outlines the features of the states that represent the five different Shimberg models. First, the states' Governance Features (independent variables) are listed below. These features may have an impact on the criteria for effectiveness (dependent variables). These Governance Features include variables that may increase or decrease the amount of funding needed to carry out statutory requirements as well as features that describe the degree of independence of the boards. By understanding these variables, we can hope to generate findings about what kinds of structure make boards effective in terms of efficiency and performance outcomes.

Table 4. Governance Features (Independent Variables) for Five Model States

IS / DOES THE BOARD…	**Oregon**	**Arizona**	**Wisconsin**	**Michigan**	**Illinois**
Independence					
administered within a larger agency	no	no	yes	yes	yes
advisory to another agency/director	no	no	no	no	yes
composed of members of the regulated profession and public members	yes	yes	yes	yes	yes
decisions reviewed by agency/commissioner	no	no	no	no	yes
members appointed by the Governor	yes	yes	yes	yes	Director and Governor[21]
Administration					
hire its own staff	yes	yes	no	no	no
appoint an ED/Board Administrator	yes	yes	no	no	no
answer inquiries from public/licensees	yes	yes	centralized	centralized	centralized
share staff with other board/agency	no	no	yes	yes	some boards have dedicated staff

Table 4. Governance Features (Independent Variables) for Five Model States					
IS / DOES THE BOARD…	**Oregon**	**Arizona**	**Wisconsin**	**Michigan**	**Illinois**
co-locate with other board/agency	informally	no	yes	yes	yes
share administrative services with other boards	informally	varies by board[22]	yes	yes	yes
contribute portion of funding to a shared administrative body	no	no[23]	yes[24]	yes	yes
share space with other board	informally	no	yes	yes	yes
conduct rulemaking	yes	yes	yes	yes, and Director[25]	no
do their own budgeting	yes	yes	no	no	no
Compliance					
discipline licensees	yes	yes	yes	yes, and Director[26]	no, Director
receive complaints	yes	yes	centralized	centralized	centralized
investigate complaints	yes	yes	centralized	centralized[27]	centralized
have in house legal representation	no	no	yes	no	yes
use AG as legal representation	yes	yes	yes[28]	yes	no
have an appeals process	yes for licensees	yes for licensees[29]	yes for licensees	must go to Court of Appeals	licensees must go to Circuit Court[30]
address unlicensed practice	varies by board	yes c&d then refer to AG	yes, Department Secretary	no	yes
hold hearings	yes	no[31]	staff ALJ	no, Dpt[32]	yes
Licensure					
administer exams	varies by board	no	centralized	centralized	centralized
contract for exam services	yes	yes	centralized	centralized	centralized
process applications for licensure	yes	yes	centralized	centralized	some have dedicated staff
administer renewals	yes	yes	centralized	centralized	centralized
verify credentials for new licensees	yes	yes	centralized	centralized	centralized
set qualifications for renewals through rulemaking	yes	yes	yes	yes	centralized
set qualifications for sitting for exam through rulemaking	yes	yes	yes	yes	no
Policy-making					
define scope of practice through rulemaking	yes	yes	yes	yes	no
sets grounds for discipline	yes	yes	yes	yes	no

Table 4. Governance Features (Independent Variables) for Five Model States					
IS / DOES THE BOARD…	**Oregon**	**Arizona**	**Wisconsin**	**Michigan**	**Illinois**
through rulemaking					
establish, change policy	yes	yes	yes	no	no
Funding					
collect fees	yes	yes	centralized	no[33]	centralized
set fees	yes, w/o Legislature	yes, ceiling set by Legislature	no	Bureau can raise fees[34]	no, Director
budget built into another agency	no	no	yes	yes	yes
pay for services to other state agencies (AG, Admin, Finance, etc.)	AG	yes AG, Office of Admin. Hearings	no	AG (not fully); Dpt of Info Tech; CIS	no
funded fully through fees	yes	yes, contribute 10% to general funds	yes, contribute 10% to general funds[35]	yes	no
receive general funds	no	no	no	no	yes
Public Education					
send newsletter to licensees	yes	yes	yes	yes	varies by board
conduct other regular activities	varies by board	varies by board	1 FTE	yes	yes

The features listed above give a more detailed description of the five model states' governance structures and the features that may impact their expenditures. The next step is to describe the models based on the Criteria for Effectiveness outlined in Table 2. Criteria for Effectiveness (Dependent Variables)to address the third purpose of the study:

3. Describe models of occupational regulation in terms of the criteria for effectiveness.

However, these criteria do not lend themselves data collection easily. Some criteria are simply too difficult or costly to account for within the scope of this project. As a result, the criteria that were measured were those most easily accounted for, but do not cover all the criteria, particularly those that fall under the general outcome, "Consumer health is protected from unscrupulous or incompetent practitioners."

What follows is a table summarizing data used to evaluate the model states based on the **process criteria**. Following the table is a narrative discussion of some of the **process and outcome criteria** that are not easily represented in tabular format.

Process Criteria

Table 5. Process Criteria for the Model States					
	Oregon (Board of Dentistry)	**Arizona (Board of Psychologist Examiners)**	**Wisconsin**	**Michigan**	**Illinois**
Time to process applications	1 day[36]	30 days	5 days	4-8 weeks	6-8 weeks
Time to process renewals	4-5 days	1 day	5 days	2-4 weeks	45 days[37]
Time to resolve complaints	7-12 months	0-6 months	12-18 months[38]	12 months[39]	1-16 months
Fee schedule	Initial License: $210 + exam Biennial Renewal: $210	Initial License: $400 + exam Biennial Renewal: $400	Initial License: most are $53 + exam Annual Renewal: $53-$168	Initial License: $40-$150 + exam Annual renewal: $20-$90	Initial license: $50-$300 + exam Annual renewal: $25-$100
Budget	$850,000	$259,800	$10,934,800	$13,300,500	$14,113,900
Number of regulated professionals	6,734	1,634	252,793	352,732	737,624
Dollar per regulated professional	$126.23	$159.00	$43.26	$37.71	$19.13
Full Time Employees	7	4	135.5	113[40]	304
FTEs per 1000 regulated professionals	1.04	2.45	0.54	0.32	0.41
Disciplinary actions	69	9	1,201	394	4,447
Disciplinary actions per 1000 regulated professionals	10.2	5.5	4.8	1.1	6

Patterns are not easily discerned from the table, and it can be misleading to try to extrapolate findings about governance structure based on the above chart because the sample size is small. Still, some general trends can be discerned. For example, more consolidated boards generally took longer to process applications and renewals than the more independent boards, which speaks to customer service. Also, the budgetary dollar per licensee varied greatly between the more independent boards and the more consolidated boards, which may be an indicator of the efficiency of the boards.

Discussion of outcome and process criteria

Table 2. Criteria for Effectiveness (Dependent Variables) describes criteria by which to evaluate boards' effectiveness. Some of these criteria are more ambiguous and more difficult to measure, but in many ways, they are more important because they account for the most important goal of public protection. In order to explore some of these criteria, this researcher interviewed regulators and board members, and executive staff at professional associations in each of the states. What follows is a discussion of the criteria that were introduced in the interview and the general responses that may indicate the level of achievement on the criteria.

Criterion: *Outside influences do not exert significant pressure on regulatory decision-making.* Almost all of the respondents from each of the five states mentioned that the professional associations in the state were active in monitoring or lobbying the boards, although it is difficult to judge the degree to which professional associations influence boards' decision-making. The responses did not vary by type of governance structure; respondents from more independent and consolidated boards had similar viewpoints. Few of the respondents indicated that they regarded the interaction as inappropriate, although one respondent mentioned that some boards allow association representatives to work directly with the board on rulemaking projects. A few respondents mentioned that the professional associations clearly had a vested interest in the activities of the boards, and were responsible, in many cases, for the board's creation in the first place. In some states and for some boards, the enabling legislation requires the Governor to consider board member appointees from a list prepared by the professional organization.

In addition, several respondents mentioned a range of individuals and consumer groups that try to lobby boards. A few respondents discussed the influence of the media on boards. Larger, more high profile boards, particularly the boards of medicine, are subject to significant pressure by various media sources.

Criterion: *Different professions are treated consistently.* This criterion applies more to boards that reside in a consolidated structure, such as Wisconsin, Michigan or Illinois, than to more independent boards. Opinions were mixed on this topic, although a few respondents from more consolidated boards reported occasional grumblings from smaller boards that felt that they did not get the priority that other boards did. In particular, with regard to agencies with consolidated enforcement functions, a few respondents complained that boards were not able to prioritize the caseload, because at times, other boards' cases took priority.

Three respondents considered unfair the fact that larger boards essentially subsidize smaller boards in more consolidated agencies. Smaller boards do not have the number of regulated professionals necessary to keep their regulatory fees low. In addition, respondents from all

models mentioned that the board of medicine in their state garnered significantly more attention than other boards and often had the most influence with the legislature and key regulators.

Criterion: *Licensure requirements are not discriminatory.* This criterion addresses the need for licensure requirements to reflect fairly the skills and experience needed to perform the activities of a given practice act without endangering the public. Licensure requirements should not intentionally or unintentionally discriminate against any group. Doing so restricts the number of professionals in a given field and raises the cost of care for consumers.

None of the respondents interviewed for this project felt that their boards' requirements for licensure discriminates against groups such as ethnic minorities or people for whom English is a second language. However, many respondents discussed their board's or agency's attempts to make accommodations for applicants who speak a first language other than English. The most common response to this question indicated that the board or agency had not discussed the topic actively. Responses did not vary by type of board structure.

Criterion: *Boards have adequate funding.* All of the 71 respondents indicated that their state's current fiscal shortfalls affected their boards' funding. Not all respondents from more autonomous boards reported financial shortfalls. All respondents from more consolidated boards who discussed funding indicated that funds were short. In Wisconsin, respondents reported chronic staffing shortages that resulted from low fees; the state's fiscal crisis prevented fee increases. Michigan respondents cited a staffing shortage that was a result not of low fees, but of the state-imposed hiring freeze. Illinois respondents generally said that funding was short due to the state's budget crunch. Respondents from states with more autonomous boards in Oregon and Arizona generally had better reports on their fiscal situation, although answers varied.

The research discusses at least two explanations for these findings. First, these responses may lend support to researchers Graddy and Nichol's comments on the financial advantages of consolidation. They theorize that, "it may be centralization does not yield any scale economies or centralized agencies may actually receive lower funding than the aggregated budgets of the individual boards they replace due to legislative anticipation of increased efficiency."[41]

Second, it may be that the affairs of larger, centralized credentialing agencies are more closely tied to the affairs of the state. This is possible because the role of a Governor-appointed director or commissioner of a department may be more politicized than the role of a board-hired executive director. The head of a department with a substantial budget may be under more budgetary scrutiny than individual boards each with comparatively small budgets.

Criterion: *Board members are qualified and capable of performing their duties.* Respondents in each state were asked to describe the training that board members receive, as well as whether or not they perceived that training to be adequate. All of the respondents indicated that board members received formal training either from the agency under which they reside, the office of the Governor, a state organization that worked with boards, or informally from the Executive Director of the board or other board members. A few respondents indicated that the training their board members received was not adequate or should be improved, but these responses did not vary by governance structure.

Criterion: *The board can be held accountable for their decisions.* Some responded to questions about accountability by saying that the board is ultimately accountable to the public or to licensees, while many indicated that the Governor appoints and can remove board members. In almost every case, the Governor or the department director appoints the board members (the state legislature or senate confirms some). None of the respondents could think of an example of the Governor censuring or removing a board member.

Criterion: *Scope of practice disputes between boards are resolved to the benefit of the public.* The discussions about scope of practice conflicts were wide ranging and without clear consensus. Seven respondents thought that scope of practice disputes between professions would always require legislative decision-making because of the political nature of the disagreements. But four others felt that having consolidated or umbrella structures helped to ameliorate disputes between professions for several reasons. First, staff and regulators at consolidated agencies were likely to communicate informally and could resolve disputes before they required legislative action. Second, some respondents felt that the legislature looked to or listened to the director of more consolidated agencies on these topics. Further discussion of the role of oversight bodies or councils in ameliorating scope of practice issues is discussed below (see Case Studies with Special Features).

Criterion: *Practitioners are aware of regulatory requirements.* For information on the opinions of regulated professionals, executive staff at professional associations were asked to give their perceptions because they are viewed by some as representative of licensees. Over half of the ten respondents from professional associations indicated that practitioners needed more education about regulatory requirements. The results did not vary by type of governance structure.

Criterion: *Boards provide good customer service to regulated professionals in terms of timeliness, courtesy and accuracy.* According to executive staff at professional associations, all three of the more consolidated states, Wisconsin, Michigan and Illinois, received lower marks for customer service than did the more autonomous states, Oregon and Arizona. About half of the respondents noted delays and difficulty in getting through the phone system at the former states, although the respondents did not appear to think the situation was critical or chronic. Similarly, reports from associations about the more independent states were not glowing, but were freer from some discussion of delays and difficulties.

Case Studies with Special Features

Three states and one Canadian province were selected for case study because of their interesting oversight structures that help to coordinate policy, conduct research and serve as an appeal body for the boards. A detailed description of these cases and the responses from interviewees can be found in Appendix C – Detailed Case Studies. Here, we will discuss the findings from that review.

Criterion: *Scope of practice disputes between professions are resolved to the benefit of the public.* Respondents from each state were asked to give their perceptions of the way their state or province manages scope of practice disputes. Resolving these conflicts to the benefit of the

public is one of the most complex issues with which regulatory bodies work, and there was no consensus among respondents on this topic.

Most respondents from Ontario and Virginia indicated that having a body to conduct objective research for sunrise legislation and scope of practice issues was very helpful to the process. Several respondents indicated that the research and objective focus of the oversight body or committee helped to focus the debate on factual material. In particular, nearly all eight of the respondents from Ontario indicated that their oversight body produced useful information for the boards and decision-makers.

On the other hand, the political wrangling between professions in Iowa is indicative of the powerful role of politics in any situation. Nearly all the respondents discussed the unavoidable role of politics in shaping scope of practice conflicts, despite the role of an oversight body.

The research on the four states with special features does not definitively indicate the degree to which oversight boards or councils are useful organizations or merely add another layer of bureaucracy to the regulatory landscape. The literature generally favors oversight structures for research, accountability and ameliorating scope of practice issues, but a minority of respondents from states with oversight structures (excluding Ontario) did not feel that their board reaped the expected benefits.

CONCLUSION

The critical question addressed by this report is, "What type of governance structure makes for the most effective boards?" The purpose of this study is threefold:

1. Explore and clarify models of professional regulation;
2. Define what it means for regulating bodies to be "effective";
3. Describe models of occupational regulation in terms of the criteria for effectiveness.

Reviewing previous studies, consulting experts in professional regulation and interviewing regulators across the states selected for case study contributed to the findings.

The findings generally support some of the Minnesota Legislative Auditor's 1999 findings: "We found no convincing evidence that any particular organizational arrangement or process provides an assured solution to any given problem associated with occupational regulation."[42] This study found that there is no way to evaluate conclusively governance structure with the available information, although some general findings can be drawn from the data.

It is difficult to generalize about the results from the data reviewed for this study for several reasons. First, isolating the variables regarding structure from the many factors that may influence boards' effectiveness is problematic. In addition, data describing many criteria that could indicate effectiveness are unavailable. Also, the case study method does not allow for extrapolation about other states' governance structures.

The answer to the critical question addressed by this study is yet uncertain. Previous studies and reports by researchers and state commissions have reached no general consensus on what type of governance structure is the most likely to ensure effective public protection in the most efficient manner. Some experts have concluded that structure may matter less than funding, staffing or leadership.

Future research may shed more light on the topic of governance structure. Additional research should consider whether or not oversight structures improve the effectiveness of regulatory boards rather than add a layer of bureaucracy to the process. Future research should also represent a broader range of effectiveness indicators, instead of relying on easily accessible data. In addition, further study should more closely examine cost structures to determine the advantages of one structure over another.

APPENDIX A – METHODOLOGY

Review of the Research

Reviewing the existing research is important to understand what experts and critics across the country have to say about the organizational structure of health licensing boards. This researcher sought reports, articles and experts from library research, online searches and through referrals, including reports written by other states' boards, Legislative Auditors and commissions.

Case Studies

Because of the difficulty of gathering detailed data for 50 states, this project employs the case study method. The advantage of using a case study approach is that it facilitates gathering detailed information. However, because of the small sample size, extrapolations to reflect on other states' circumstances are unreliable. Case studies are helpful for creating detailed descriptions, but are no substitutes for more comprehensive statistics that would more accurately describe relationships between independent and dependent variables. Case studies allow other states to compare and contrast their situation with those in the case studies. Case studies were selected based on several factors.

- States perceived as an effective model
- States perceived as an ineffective model
- States with similarities to Minnesota
- States with dissimilarities to Minnesota
- Availability of information
- States that are geographically or demographically similar to Minnesota
- States that are commonly compared to Minnesota
- States should represent the five models of governance structure

Selecting Interviewees

In order to develop a comprehensive representation of each state selected for case study, interviews with several regulators from each state were conducted. Initial interviewees were selected at random by an internet search of boards' executive directors or board liaisons. Next, interviewees were asked to suggest others in the state. This researcher attempted to reach interviewees that represented a wide range of occupations as well as large boards and smaller boards in each state.

Interviewees were divided into groups (see Appendix D – Surveys):

- **Survey one:** Staff were asked questions regarding the governance features (independent variables) listed in Table 1.
- **Survey two:** Board members and executive staff were asked questions regarding the criteria for effectiveness (dependent variables) listed in Table 2.
- **Survey three:** Executive staff at professional associations were asked questions relating to the criteria for effectiveness (dependent variables) listed in Table 2.

APPENDIX B – RESEARCH REVIEW

The following discussion reviews some of the literature on health professional regulation. For findings, see Findings from a Review of the Research, on page 5.

Previous Studies

Some researchers have attempted to show empirically the impact of professional licensing board governance structure on various measures of effectiveness. However studies are not comprehensive.

- Researchers Elizabeth Graddy and Michael Nichol conducted a statistical analysis of the effect of consolidation on disciplinary decisions. Results were mixed. They found that administrative centralization of health licensing boards negatively impacted the number of disciplinary actions; "This suggests that overall administration centralization is not only ineffective at improving consumer-oriented performance, it is actually counter-productive."[43] However, the researchers also found that the number of disciplinary actions increased when investigative, rather than administrative, functions were centralized and when the number of investigative staff is higher.[44] They tentatively concluded that resources rather than structure may influence performance, but that "the hypothesized advantage of centralization may apply for some specialized functions."[45] This study did not attempt to calculate the impact of structure on indicators of effectiveness other than on disciplinary action.
- The Arizona Auditor General (AAG), in 1995 found that "Although consolidating board functions is theoretically appealing, it has not proven to protect the public any better than completely autonomous boards." Assuming that more disciplinary actions protects the public better than fewer actions, the AAG analyzed disciplinary data from various states and concluded that "the most consolidated states are often associated with fewer disciplinary sanctions per thousand licensees than other, autonomous boards."[46] The AAG did not examine other measures of effective governance.
- In addition, the AAG cited a study by the Arizona Office for Excellence in Government, in which the study comparing 19 health licensing boards was eventually dropped when it concluded that "no large dollar savings would be realized by combining the boards."[47]
- A study of reorganization efforts in state governments' executive branch indicated that even though states often reorganize with the goal of achieving greater efficiency, actual savings occurred in only six of the 22 states. In three of these, savings were modest.[48]
- The Texas Health and Human Services Commission reported that "there has been no definitive research conducted that identifies any single model as the best, each having its own advantages and disadvantages. The evidence seems to indicate that independent boards may receive more complaints and take more disciplinary actions."[49]
- The National Council of State Boards of Nursing (NCSBN) is currently in the process of identifying "best practices" for state licensing boards. The NCSBN researchers have found that many of the "best practices" were not dependent on board structure. The study identified "Processes That Work," or processes that support the best practices. These included giving boards the authority to hire or directly contract with investigators and attorneys involved with the disciplinary process. In fact, of the boards that scored high on a rating of "predictor

variables," none were umbrella boards. Also, effective boards were found to be those that had a clear understanding of the roles of the board members and staff, indicating that the board members did not micro-manage staff functions but rather trusted staff to fulfill the mission established by the board.[50] Future publications by NCSBN may shed more light on these issues.

The existing studies do not achieve consensus on the issues related to governance structure, but do elaborate on certain elements of structure, particularly as it affects the number of disciplinary actions. The evidence presented above tentatively supports the advantages of independent licensing boards in disciplinary matters, and is ambivalent about costs savings resulting from reorganization. It should be noted that successive researchers have not repeated the studies outlined above, therefore their reliability (ability to get the same results with repeated tests) is uncertain.

Perceived Benefits and Detriments of Independent and Consolidated Boards

Despite the ambiguity of the evidence relating to governance structure, there is no shortage of opinions about the benefits and detriments of an independent board model versus a more consolidated or umbrella model.[51]

Administrative efficiency and customer service

Some experts argue that consolidation can save boards money by eliminating redundant administrative elements such as office space, IT implements and equipment, particularly for smaller boards that require high fees to support administrative activities.[52] Some think that larger, umbrella agencies are more efficient because of staff specialization and economies of scale. However, proponents of independent boards argue that because staff are cross-trained, they are able to provide better customer service to licensees and are more efficient because staff can see transactions through the process instead of relying on other staff to complete the process. In addition, although some think that consolidated boards facilitates streamlined processes for compliance matters, others think that independent boards are more effective because they are able to prioritize caseloads more fairly.[53] In terms of efficiency, Graddy and Nichols (see section Previous Studies) reason that

> Centralized agencies were assumed to have more resources per licensee than individual boards because of cost savings from scale economies. However, it may be that centralization does not yield any scale economies or centralized agencies may actually receive lower funding than the aggregated budgets of the individual boards they replace due to legislative anticipation of increased efficiency.[54]

In addition, the Council of State Governments cautions policymakers who assume that efforts to reorganize executive branch agencies will result in cost savings. They say that the political influences of budget making often result in a negation of savings.[55]

Accountability

Although most experts agree that holding boards accountable to the public is important, few agree on which model improves accountability. Some claim that independent boards have clear lines of authority and have greater control over allocation of funds. But others maintain that consolidated entities enable the legislature and the Governor to have better oversight of the

boards. Advocates of consolidation also argue that consolidated boards are more likely to be consumer-oriented than independent entities because of the centralized oversight[56] and because of greater visibility and clarity to the public.

Consumer access

Different experts argue that each type of board has advantages in terms of access by consumers: whereas independent boards have clear lines of authority and are more likely to provide access to a live person on the phone, some think that the multiplicity of independent boards confuses consumers.[57] Some claim that consolidated boards have better visibility to consumers and therefore make it easier for consumers to lodge complaints.[58] But opponents counter that umbrella organizations are generally difficult to navigate which thwarts consumers' efforts to get information or keep boards accountable.

Because empirical studies on this topic are few and less than comprehensive, it is difficult to know whether any of these arguments result in better or worse public protection, the goal of all credentialing agencies.

Issues Affecting Board Structure

What follows are some of the issues that repeatedly emerged in the literature, and their possible implications for governance structure.

Discipline

The disciplinary function of occupational regulation is essential to the public protection mission, as boards attempt to ensure that licensees are held accountable for substandard care as well as to deter future negligence or malfeasance. Disciplinary actions are the most visible and comprehensible actions that most boards take. Also, because of the sensational nature of some claims, disciplinary activities attract the most interest from the public and the media, particularly for larger boards such as those regulating medical practice or nursing. In addition to the visibility of compliance operations, data that describe disciplinary actions are often available to the public and easily communicated. Other data that could also measure board performance are often more opaque and difficult to come by.

As a result of the interest generated by disciplinary functions and the accessibility of the data, many experts and academics use data on disciplinary actions to signify board performance. Sidney Wolfe, of the nonprofit consumer advocate organization, Public Citizen, yearly ranks states' medical licensing boards according to their "performance" on disciplinary matters. The report ranks each state according to the number of serious disciplinary actions per 1000 licensees; those states with more actions are ranked "high."[59] The Public Citizen publication generates significant media and political attention for many boards yearly.

Many regulators and experts criticize the report as a misleading and one-dimensional perspective on boards' performance. The Public Citizen report does not take into account many factors which may better account for the variations in disciplinary action. For example, the report does not account for the number of complaints filed, the public education efforts of the boards, the extent to which the credentialing process screens out unqualified or unethical professionals, or the actual effects of disciplinary action. The underlying assumption of the report is that every

state has the same proportion of incompetent or unscrupulous physicians, and those states with higher levels of action come closer to removing the offending professionals.[60]

The discussion about disciplinary actions does not shed light on the most effective governance structure for handling disciplinary matters. Some argue that umbrella agencies can better handle disciplinary matters because they can more easily standardize disciplinary procedures and actions. Standardization is beneficial, it is argued, because it relies less on board members' personal judgement and more on objective criteria for disciplinary action.[61]

In addition, discussions about discipline and board structure relate to the manner in which compliance staff are organized within a board or agency. Proponents of independent boards argue that having investigative staff work for several boards at once dilutes the staff's expertise and renders them less effective than if they were dedicated to one occupation. In addition, independent boards can prioritize cases as they see fit,[62] which can be positive or negative, depending on one's perspective.

Evidence on the topic is scant, but the NCSBN researchers found that boards being able to hire their own investigators were beneficial because they were able to correct minor inefficiencies and issues as needed because they were in direct control of the staff.[63] However, some experts claim that the effectiveness of disciplinary processes is dependent less on board structure and more on the resources attributed to the compliance process.[64]

One structural option is to create a body to review decisions by licensing boards. For example, in Ontario, an all-public Health Professions Appeal and Review Board (HPARB) examines decisions by the various independent colleges (boards) in the province (see section Ontario). HPARB only considers whether the decision made by the college was reasonable and cannot overturn a decision, but rather can send the decision back to the college for reconsideration, with recommendations on the process. Having an all-public review board could increase consumer confidence in the system, help to standardize disciplinary processes among boards, and keep appeals of board decisions out of costly courts.[65]

Scope of Practice[i]

Disputes between professions over authorization to perform specified procedures are at the heart of much discussion among experts in the field. Scope of practice disputes, are important because the result of these disputes directly impacts consumers' access to care.

The Pew Health Professions Commission, Taskforce on Health Care Workforce Regulation (Pew Commission) is a widely cited working group that made recommendations for reform. The Pew Commission recognized that scope of practice disputes are sometimes about more than public protection, but also about "turf" protection for the professions involved,

> Current statutes grant broad, near-exclusive scopes of practice to a few professions and "carved-out" scopes for the remaining professions. These laws erect unreasonable barriers to high-quality and affordable care. The need for

[i] Several states and provinces have established oversight bodies partly to do the work suggested in this section. This report will look in depth at the Texas Health Professions Council, the Virginia Board of Health Professions, the Iowa Scope of Practice Review Committee, and the Ontario Health Professions Regulatory Advisory Council.

> accessible health care calls for flexible scopes of practice that recognize the demonstrated competence of various practitioners to provide the same health services.[66]

Scope of practice conflicts present several obstacles to the delivery of quality care. Turf battles cause professions to struggle for protection of their practice territory rather than for the benefit of consumers. This artificially restricts the supply of professionals and impedes consumers' *access* to the care they need. Restricted supply of competent professionals may especially impact emerging alternative and complimentary professions,[67] a growing part of the health care landscape.

To address these difficulties, the Pew Commission recommends basing practice acts on "demonstrated initial and continuing competence" rather than as a reward for the profession,[68] but what does that imply for board structure? How can governance structure facilitate the amelioration of scope of practice conflicts to the benefit of the public?

Some argue that consolidated boards could help to mitigate disputes between professions for several reasons. Consolidated boards are likely to share space and therefore may facilitate informal information sharing and cooperation among board staff, thereby heading off otherwise contentious conflicts. The Pew Commission recommended that boards be designed to reflect the interdisciplinary nature of the health care system; they suggested consolidation of boards around general professional or service areas to facilitate interaction and integration between professions' scopes of practice.[69]

Others contend that boards need "formal mechanisms for regular inter-professional dialogue to discuss shared regulatory policy issues," and to "reduce turf battles."[70] Many recommend oversight boards or councils charged with resolving conflicts to benefit the public or making recommendations to the Legislature on change in statutes. The Pew Commission proposed that either "a publicly dominated oversight board or council or centralized administrative oversight by an executive agency branch or office" oversee boards.[71]

None of these proposals have been evaluated thoroughly, although one report claimed that establishing an oversight agency did not lead to an increase in disciplinary actions.[72] Also, one expert recommended that in order to be effective, any type of oversight body formed must have "buy-in" from the boards it oversees.[73] This may favor an entity created statutorily as opposed to a voluntary membership, especially because ultimately the state legislature makes decisions to change a scope of practice.

The Role of the Consumer

Health professionals constitute the majority of members of health licensing boards on virtually all boards in the country. Discussions for decades have questioned whether this presents a conflict of interest for the professional members and whether a board can adequately protect the public when the public has so little involvement. Although virtually all boards across the country include at least one "public member," few agree on how effective the membership of one or more public members is at representing the public.[74] Because of the focus on board structure,

this report will not analyze the situation of public members, but rather will discuss options for improving the consumer-orientation of existing boards through various means.

Despite the inclusion of public members on boards, open meeting laws, and the expressed mission of boards as existing to protect the public, most boards seem to exist "below the radar" of much of the public.[75] Several interviewees expressed the viewpoint that most consumers are unaware of the boards' existence, unless there is a problem with a practitioner.[76] Consumers are often confused about which board to call when they have a question or a complaint about a professional or what is the role of the boards, and boards often do not have the funding available to publicize their activities extensively.[77]

Some consumer advocates think that centralized access to information about the boards is beneficial for consumers to make the confusing system more accessible.[78] Centralized boards often have a common toll free number for consumer requests and some independent boards have cooperated to install a common phone number for complaints, where a central operator distributes calls to the respective boards. In Texas, legislation passed in the last year will enact an Office of Patient Protection. This office will work under the Health Professions Council (see section Texas) and will provide information and guidance to consumers about the complaint process and will also appeal decisions of the boards for consumers as a class, although not as individuals.[79]

Maine has a distinctive approach at representing consumers: the Legislature created the Consumer Assistant position at the Board of Licensure in Medicine in 1998. The purpose of the position is not to advocate for consumers, but rather to keep them informed of the adjudication process and to assist them in understanding the processes of the boards. In addition, the Consumer Assistant ensures that the boards understand the complainant's concerns and gives feedback to the board on complaint procedures.[80]

Politics

As with most public entities, licensing boards' activities are infused with politics; some critics even question the utility and motivation for public regulation to begin with.[81] One critic states,

> This ostensible goal of professional regulation – to establish standards that protect consumers from incompetent practitioners – is eclipsed by a tacit goal of protecting the professions' economic prerogatives. This dichotomy of goals has created serious shortcomings that include limited public accountability, support for practice monopolies that limit access to care and lack of national uniformity.[82]

The politics of professional regulation are multi-faceted, and an extensive discussion is beyond the scope of this report. However, a few topics are worth mentioning to help frame the issues within which licensing boards operate.

- Although the public often does not understand what they have to lose or gain by professional regulators' actions, professional groups associated with the boards clearly understand their stake in the boards.[83] Professional associations lobby boards and state legislatures for changes that would affect them; these professional associations do not always have the public's best interests in mind. Conversely, consumer groups do not have the organizational resources to monitor the myriad decisions made by boards and state

legislatures. As a result, decision makers are frequently pressured by professional groups, but only rarely lobbied by others.[84]

- A change in health professionals' regulations does not often arise because of public outcry or because of the initiative of an elected official, but rather almost always originates with the profession.[85] These changes are often criticized as protecting the practice of the profession rather than looking out for the best interests of the public.[86]
- Similarly, initial regulation often stems from the interest of the unregulated profession rather than public outcry. Critics claim that professions do not seek public protection, but rather want legitimacy, turf protection, restriction of the supply of professionals or reimbursement by insurance companies that will not recognize unlicensed professions.[87]

The best board structure should be one that minimizes the influence of biased parties and ensures accountability for decisions made by the boards. As discussed above, some claim that independent boards' direct lines of accountability minimize bias. Others think that single-profession boards are often too close to their professional groups, but that multi-disciplinary or advisory boards have an added layer of protection against bias. However, consolidated boards generally are headed by a director appointed by the Governor, which introduces another level of politics into the mix.

APPENDIX C – DETAILED CASE STUDIES

This section addresses the first purpose of the study:

1. Explore and clarify models of professional regulation

What follows is a detailed description of the states selected for case study, as well as a summary of the responses from interviewees in each state.

Model Representatives

Oregon

Shimberg classifies Oregon as Model A: Independent Boards. However, this characterization belies a system in which different occupational boards have different structures. In their 1997 evaluation of the organizational structure of the credentialing entities in the state, the Oregon Department of Administrative Services, Budget and Management Division declared, "Oregon occupational licensing boards operate under several different service delivery models. There is not one service delivery model that works for all boards."[88]

Some boards are stand-alone state agencies that are subject to state rules regarding budgeting, personnel, accounting, etc. Other boards, like Medical Practice, Nursing and Psychological Examiners, exist as "semi-autonomous" and are not subject to these regulations. Semi-autonomous boards can raise fees without Legislative approval, bank outside the state treasury, and are not subject to administrative and budgeting rules. These boards have the power to lease property as needed and allocate board members' per diem, but are subject to increased accounting oversight.[89]

In contrast, a few small boards have some degree of dependency on the Department of Human Services. For example, the department appoints board members for the Board of Examiners of Licensed Dietitians.[90] The power to set fees varies by board: some boards set fees under a ceiling imposed by the Legislature; others must get approval for fee changes by the Department of Human Services. In addition, several small boards with few staff have inter-agency service agreements with the Department of Administrative Services to provide assistance with budgeting and cashiering.

In 1999, nine small boards were placed under the administration of the Health Licensing Office (HLO), located within the Department of Human Services.[91] This office performs administrative functions for each profession, some of which have their own boards. The Director and the managers of Administrative Services and Regulatory Operations collaborate to design and execute uniform policies for the boards under their purview. The Governor appoints the board members and the Director of the HLO sits on each board, ex officio.

Interviewees' Responses

- The autonomous boards seemed to be content with their status as independent entities unaffiliated with an umbrella organization. One respondent commented that they have a situation that is "close to ideal here." Several said that they liked the autonomy of being able to hire their own staff although others who held interagency agreements with larger agencies were satisfied with their situation as well.

- Despite a severe statewide budget shortfall, none of the four respondents from independent boards complained of a funding shortage, which is likely due to the fact that they have some discretion in setting fees apart from the Legislature.
- Two respondents commented that being collocated with other health licensing boards was helpful to them. They are able to share information and benefit from each others' experiences.
- The director of the HLO felt that boards attached to the office benefited from the consolidated functions because their small number of licensees makes it difficult to fund adequate numbers of staff.

Arizona

Arizona is classified as having "Shared Administrative Functions" (Model B), although some boards are more autonomous than the title implies. The Department of Health Services (DHS) regulates four professions. Three of the occupations under DHS have advisory boards, appointed by the Department Director, and the Director has "final authority for licensing and enforcement decisions."[92]

The 19 boards outside of DHS are fairly independent. The Governor appoints, and the state Senate approves the appointment of all board members. All boards have the authority to license and discipline individuals. Some operate under an inter-agency services agreement with the Department of Administration to provide services such as payroll, accounting, budgeting and a phone bank.[93] Other boards do not participate in the agreement, and provide these services themselves.

One notable feature of the Arizona boards is the "90/10 Rule." Licensing boards must pay ten percent of their revenues into the state's general funds.[94] Boards still must go to the Legislature to re-appropriate their revenues for use.[95] Another anomaly is that although the boards exclusively use the Attorney General's office for legal support, they do not compensate the Attorney General's office for those services.

Various efforts to consolidate the boards have not come to pass. In the beginning of the 2003 Legislative session, the newly elected Governor had been promoting the idea of consolidating the health licensing boards' administrative functions into a single agency. The motivation included cost savings and empowerment for smaller boards that would gain a collective voice. However, this plan did not proceed partly because of low gubernatorial priority.[96] Also, several years ago, the Board of Pharmacy proposed to the other boards that they form an administrative cooperative that would manage verifications, renewals and other common functions. Other boards did not support the plan and it did not go forward.[97]

Interviewees' Responses

The respondents represented five different independent boards as well as the Department of Health Services and the Governor's office.

- The interagency services agreement is an efficient way of assisting twelve smaller boards with accounting, payroll, budgeting and a phone bank.

- Reactions about funding for the boards varied; three of the independent boards said their funding was sufficient, whereas two said that their appropriations were too low. Some lamented the 90/10 system, while others were satisfied with it.
- All the respondents were positive about the current structure of the boards. Respondents stated that the independent nature of the boards positioned them best to protect the public. Several spoke of the possible inefficiencies that would result from consolidation under an umbrella organization.

Wisconsin

Wisconsin is classified as having "Shared Authority," Model C, although 23 occupations do not have boards and are regulated directly by the Department of Regulation and Licensing (DRL). DRL administers all the credentialing boards in the state, including non-health related professions. Central staff handle applications for licensure, verifications, renewals, newsletter publishing and a common phone line. The boards do not hire an executive director, but rather they share a division head among many boards.

For the 25 occupations that have boards, the boards have authority over rulemaking, disciplinary action and licensure requirements. Boards are not advisory to DRL on these actions, although they receive help from the Department as needed.[98] The Department collects fees for initial licensure, renewals, etc., and contributes ten percent of those fees to the state's general fund.

DRL manages the complaint process for each occupation. Cross-trained department attorneys and administrative law judges investigate and adjudicate complaints. Attorney general services are only used to represent the Department when a licensee appeals a board's decision to the courts. The Attorney General's office is not reimbursed by DRL. The compliance staff is shared collectively among the boards and the Department promulgates rules regarding "receiving, filing and investigating complaints."[99] There is also a common toll-free number by which consumers can file complaints. However, each board has final disciplinary authority over its licensees.

Interviewees' Responses

The tone of responses from regulators and DRL staff in Wisconsin was less sanguine than the responses from other states.

- Reactions to the overall board structure were mixed. About half the respondents were satisfied with the structure and the Department's services to the boards, while others expressed a desire for more control over certain administrative and compliance functions.
- Despite the low fees three respondents stated that they perceived that licensees would be willing to pay higher fees to obtain dedicated services from the Department or an independent board. In addition, a few respondents expressed dissatisfaction with their perception that boards with more regulated professionals were in effect, subsidizing the fees of boards with fewer regulated professionals. Two respondents commented that regulated professionals in Wisconsin enjoy some of the lowest fees in the country.[100]
- Several respondents discussed the understaffing and under-funding of DRL. They indicated that service had suffered or will suffer, because the Department could not raise the money necessary to hire more staff. Respondents indicated that shortfalls were particularly

evident for enforcement, because staff may not be able to prioritize cases as the boards would otherwise.

- One respondent commented that the Wisconsin state leadership has long neglected the Department, resulting in chronic under-funding and a lack of technological innovation.

Michigan

Shimberg classifies Michigan as Model D, "Limited Board Authority." Within the Department of Consumer and Industry Services, the Bureau of Health Services (BHS) houses the credentialing boards of all health professions. BHS handles most of the administrative services for the various credentialing boards, including license applications and renewal processing, continuing education and compliance.

Occupations have their own boards that make some decisions on rulemaking and determine the guidelines for education and training of licensees. The Director of the Department sits on each board ex officio and does not vote. But boards do not have the range of authority of boards in more independent states. The Director of the Bureau is the chief policy maker and the Director has the authority to initiate and write rules.[101]

Disciplinary proceedings are somewhat unusual at BHS. Boards share staff for all administrative and investigatory functions, although they have authority over final disciplinary actions. These actions are formulated in disciplinary subcommittees composed of three professional board members and two public board members and chaired by a public member. The subcommittees were created to give more influence to public members over disciplinary matters. Another interesting component of the Michigan system is that the Compliance Division is required to investigate professionals who have been the subject of three or more malpractice lawsuits, regardless of the outcome of those suits.[102]

The Michigan model differs from that of Wisconsin in a few important ways. First, the Michigan Bureau of Health Services only serves health professions, as opposed to the Wisconsin Department of Regulation and Licensing which services all credentialed occupations, such as barbers and cosmetologists. Next, boards associated with BHS do not have absolute rulemaking authority as they do in Wisconsin. Also, BHS does not use in-house attorneys for their legal representation in disciplinary matters, as does DRL, but rather BHS uses the Office of the Attorney General.[103] Unlike DRL, BHS contracts with other departments, namely the Department of Consumer and Industry Services, in which it resides, for some services like fees processing, payroll and hearings with administrative law judges. In addition, the Director of BHS can raise fees, within certain statutory limits, while raising fees in Wisconsin requires an act of the Legislature.

Interviewees' Responses

- Although the Director of BHS has the authority to raise fees, the Bureau is subject to the same hiring freeze that all state departments are experiencing due to the statewide budget shortfall. Because of this, staffing has been short for some divisions within BHS, which may lead to slower service for licensees and consumers.

- Scope of practice issues arise in part because the Michigan health code is somewhat vague. However, several respondents noted that these issues were ameliorated in part because of the involvement of the Bureau director who has oversight over the boards in terms of policy-making. Also, one respondent commented that the umbrella board is helpful because the various staff communicate with one another, and because the Legislature listens to recommendations from the Director, who can act as a disinterested party.
- The Director of BHS is very involved in policymaking while the boards are less involved than boards in states with more independent boards like Oregon, Arizona or Wisconsin. Boards are discouraged from interacting with the Legislature.

Illinois

Boards in Illinois serve in a strictly advisory capacity and are part of a "Centralized Licensing Authority," Model E. Boards make recommendations to the Director of the Department of Professional Regulation (DPR) on matters of discipline and licensure. All regulated occupations in the state are overseen by DPR. The Director of the Department appoints board members except for members of some larger boards, whose members are appointed by the Governor.[104] The Director of DPR is empowered to set and change fees. DPR also handles policy development among the boards.

Within DPR, the Division of Administrative Services supports all of the boards' administrative needs. The Division of Enforcement oversees investigations and administrative hearings for all professions although some of the Enforcement staff are dedicated to health professions only. The DPR Director makes the final decisions on discipline, with advice from the boards. However, some larger boards like the Medical Licensing Board and the Board of Nursing retain their own dedicated staff to process applications for initial licensure and have investigators dedicated only to one board.

The Illinois structure differs from that of Michigan and Wisconsin primarily because of the advisory nature of the boards. The Director of the Department makes all final decisions on licensure and discipline. In addition, Illinois and Wisconsin's centralized departments regulate all types of professions, whereas the Michigan BHS only regulates health related professions. Interestingly, although Illinois is classified as Model E, and therefore boards under the system should have the least authority over staff, a few larger boards do have dedicated staff, whereas no boards in Wisconsin and Michigan have their own staff.

Interviewees' Responses

- Respondents from Illinois did not voice great dissatisfaction with the Illinois system. Most declared that they were generally content with services and expressed the viewpoint that having a consolidated system assured some degree of consistency in policies and disciplinary actions among the boards and also helps to reduce political influence.

The table below summarizes some of the features among the five states representing the five Shimberg models.

Table 6. Key Features of Five Model Representatives					
	Oregon (independent Boards)	**Arizona**	**Wisconsin**	**Michigan**	**Illinois**
Shimberg Classification	A – Autonomous Boards	B – Shared Administrative Functions	C – Shared Authority	D – Limited Board Authority	E – Centralized Licensing Agency
Administration	Board-hired staff perform administrative functions.	Board-hired staff perform administrative functions. Some boards have agreement with Dpt. Of Administration.	All administrative functions are performed by DRL staff.	All administrative functions are performed by CIS staff.	All administrative functions are performed by DPR staff.
Licensure and disciplinary authority	Board makes final decisions.	Board makes final decisions.	Board makes final decisions.	Board makes final decisions. Director can summarily suspend licenses in some cases.	Board advises Director.
Compliance	Board-hired staff perform investigations. AG assists.	Board-hired staff perform investigations. AG assists.	Department staff perform investigations. AG represents on appeals.	Department staff perform investigations. AG assists. Department required to investigate licensees with multiple malpractice cases.	Department staff perform investigations. In house counsel.
Funding	Fully through fees	Fully through fees. Pay 10% to general fund.	Fully through fees. Do not compensate AG. Pay 10% to general fund.	Fully through fees. Compensate AG, but not fully.	General fund and fees.
Fee changes	Some boards must get changes approved by the Legislature. Some can change without approval.	Legislature sets a ceiling under which the Board can set fees.	Legislature sets fees.	Legislature sets fees; can be increased yearly at same rate as COLA wage adjustments.	Director sets fees.
Appoints Board	Governor	Governor	Governor	Governor + Director of BHS sits on Board ex officio	Director of DPR

Case Studies with Special Features

Texas

The interesting feature of the Texas occupational regulatory system is the Health Professions Council (HPC), which functions like Minnesota's Administrative Services Unit and the Council of Health Boards. Although Texas is classified as Model C (Shared Authority) in the Shimberg scheme, only the professions regulated by the Department of Health's Division of Professional Licensing and Certification operate with shared authority; the boards that make up HPC retain much autonomy.

The Legislature created HPC to take advantage of the benefits of consolidation while avoiding the detriments that regulators perceived as endemic in consolidated boards: inferior customer service and inefficiency.[105] Although the Legislature mandates membership in the Council, participation in initiatives is voluntary and HPC has no authority over the boards. HPC is funded through prorated contributions from the member boards. The Council itself is made up of the executive directors of 13 boards plus a representative from the Governor's office and a representative from the Texas Department of Health.[106] HPC has three full-time employees (including one network manager) that serve the needs of the Council. Under coordination from HPC staff, the boards are co-located and share office space, office supplies, a computer technician and front office staff who operate a central toll free complaint line for all the boards. HPC also provides training to new board members and sponsors seminars for staff on topics like insurance and benefits.[107]

The members of HPC meet to work on policy issues relating to all the boards. HPC staff track legislative bills and represent the boards on policy initiatives.[108] Recently HPC staff conducted a study of the boards' disciplinary processes to try to help boards standardize their process. HPC also coordinates the formation and work of the committees, composed of the boards, which make recommendations to the Legislature on statutory changes.

Interviewees' Responses

Responses from interviewees were mixed; respondents generally saw HPC as beneficial to the boards, but many also saw shortcomings in the structure and activities of the Council.

- The health-related licensing boards that form HPC benefit from co-location and cooperation. The staff at the boards benefit from the social capital generated from dialogue and sharing information on best practices and policymaking, as well as informally settling issues over matters involving a licensee from one occupation infringing on the scope of practice of another occupation.
- HPC is helpful for several administrative functions that particularly small boards may have trouble providing for themselves. For example, HPC staff assist with payroll, budgeting and human resources issues. In another example, the boards cooperated through HPC to write a draft policy on a topic required of all the boards, saving each board the time and expertise needed to write a policy separately.
- The consolidated toll free phone number to report complaints has had mixed success in the sense that it receives many phone calls unrelated to complaints but that need to be triaged

to different boards or state agencies. However, HPC believes that with more public education, it could be an effective way to manage complaints.

On the other hand, a few respondents pointed out ways in which HPC was less than helpful.

- A couple of respondents did not find HPC helpful to their board; some commented that they were putting in more money than the value of what they were receiving.[109]
- Others said that HPC did not serve much of a purpose, but rather only added another layer of bureaucracy to the tasks of licensing boards.
- HPC could do better at being a clearinghouse for information that would be helpful to the boards as well as the public, said two respondents. HPC could be the first point of contact for consumers who do not know the proper board to contact.

HPC does not have an official role in scope of practice issues. But the informal role they play in generating dialogue and encouraging understanding and cooperation is theoretically appealing. Respondents' perceptions of HPC's role in scope of practice conflicts are not clear. While some respondents seemed to think that encouraging the boards to meet and cooperate did remedy some conflict, others thought that these conflicts can only be resolved in the Legislature. One respondent commented that having HPC get involved in scope of practice issues would merely add another layer of bureaucracy to the problem, rather than remove complications. But others thought that the Legislature would appreciate having advice from an educated body that was somewhat neutral on controversial topics.

Virginia

The Virginia health licensing boards make up the Board of Health Professions (BHP). The Board is composed of 13 board members from the individual boards and five public members. "One of the chief responsibilities of the board is to advise the Department Director, the Secretary of Health and Human Resources, the Governor, and the General Assembly on matters relating to the regulation of health care providers."[110]

Like Texas' HPC, the Virginia BHP is composed of all the health professions boards, although board members instead of executive directors represent the boards. The Governor appoints members to BHP. Also like Texas, the BHP has a small staff that carries out the work of the Board of Health Professions. However, unlike Texas, the BHP does not perform administrative functions for the boards, but rather only conducts research and policy coordination.

The General Assembly of Virginia assigns BHP projects on matters like establishing criteria by which to judge whether or not new professions should be regulated. It is also required to evaluate the compliance process of the Department and the individual boards periodically. Occupying most of their time is the BHP's role in making recommendations to the General Assembly on the initial regulation of unregulated professions. The BHP is also charged with approving all health board budgets.[111] Currently, BHP staff are working on a study that examines disciplinary actions, with the goal of helping to standardize actions among boards in the future.

Interviewees' Responses

- The role of the BHP in scope of practice issues for the boards is limited and unofficial. Although BHP has no formal power over the member boards, three respondents said that the

General Assembly does listen to the recommendations of the Board. The executive director of BHP commented that the Board could play a greater role in mediating scope of practice disputes, but because of the politics involved, most seek the General Assembly for this purpose. She also commented that one benefit of the BHP with regards to scope of practice is the fact that legislators can use BHP's recommendations to focus conversation on objective issues as well as use BHP as an outlet or "easy out" for contentious issues.

- Others questioned the usefulness of the Board. Some indicated that the BHP seemed like an added layer of bureaucracy that was informational rather than an effective organization.

Iowa

The unique feature of the Iowa regulatory landscape is the Scope of Practice Review Committee, established in 1997 by the General Assembly and funded through licensing fees.[112] The Committee was created because

> In the last 25 years there has been an expansion in both the number and diversity of health practitioners. Advances in knowledge bases of these professions have created an overlap in the scope of practice between and among them. In some cases, third-party reimbursement policies drive scope of practice conflicts…The current system for resolving scope of practice disputes is inadequate. In the past, these disputes were resolved only through legislative action, through heated battles in the administrative rule making process, or though informal negotiations between licensing boards.[113]

The purpose of the Committee is to perform an "impartial, analytical assessment using established objective criteria," (sic)[114] in order to make recommendations to the General Assembly regarding occupations seeking initial regulation, changes in an existing scope of practice or rulemaking disputes between boards. The Committee provides a process to review "public policy issues outside the political arena."[115]

Professional associations that wish for a change in regulation can request that the Iowa Department of Public Health convene the Committee, or the General Assembly can direct the Department to convene the Committee. The Director of the Department appoints the five members:

- one member of the occupation petitioning for a change in scope of practice
- one member from an occupation that would likely be affected by the change
- one member of a health profession that will be unaffected by the change
- two public members

Once convened, the Review Committee uses four criteria established by the Iowa State Board of Health to evaluate the dispute:

1. The present condition creates a situation of actual or potential harm or danger to the public.
2. The proposed change does not impose any significant new harm or danger to the public.
3. The public health, safety and welfare are reasonably expected to benefit from the requested change.
4. The public cannot be effectively protected by other more cost-effective means.

To address these criteria, the Committee's procedure can include public hearings, expert testimony and contracted research and generally includes presentations from parties supporting

and opposed to the legislation. Once they have voted on the recommendations, the Committee submits its recommendations to the General Assembly for consideration. The General Assembly is under no obligation to abide by the recommendations. In the first three years (1997 to 2000), six Committees were convened.

The administrative code leaves certain components to the discretion of the Committee. For example, because it is not clear from the code whether the application must meet all four of the criteria in order to be considered for recommendations, different committees have interpreted this differently. While some have refrained from making recommendations when not all the criteria have been met, other committees have made recommendations based on the findings from the proceedings. Also, some committees have stipulated that the applicant submit legislative language to be the subject of the proceedings and then their opinion culminated in the rejection or endorsement of the text. This all-or-nothing process insures that applicants conduct adequate research before the process begins and that the process is not used as a negotiation platform.[116] However, other committees have used legislative language as a starting point for negotiation.

Interviewees' Responses

Reactions from seven respondents who experienced a Scope of Practice Review Committee were generally negative, although all reported some benefits from the process.

- Several respondents questioned the utility of a process that may add another layer of bureaucracy to the process of regulating occupations. The Committee's recommendations have no binding authority and the General Assembly still must make the final decision regarding the applicant's request. Therefore, applicants or opposition parties that are dissatisfied with the result of the Committee's deliberations can simply take their case to the legislature, as they would have done without the Committee's proceedings. In effect, the process does not necessarily result in de-politicization.
- Most respondents agreed that the Committee does have the potential to focus the legislative debate on objective policy issues. One respondent explained that some Committees resulted in outcomes that were not predictable given the discrepancies in political power of the opposing groups. In addition, some members felt that the process gave the General Assembly an "easy out" when it faced tough decisions, which then added focus to an otherwise partisan debate.
- In one example, the applicant participated in the Committee process, but did not forgo lobbying of legislators. In the end, the General Assembly did not abide by the recommendations of the Committee but rather sided with the lobbying party. However, the applicant had incorporated into their bill some of the recommendations of the Committee, so the Committee process did influence the outcome, however indirectly.
- Two respondents indicated that in the future, they would prefer to bypass the Committee process in favor of simply going to the legislature for change in scope of practice. However, it was not clear that the General Assembly would go forward with the request for a change in scope of practice if the party had not gone through the Committee process.

Ontario

The Ontario professional regulation system is different from that of any U.S. state. A key difference is the fact that professionals join "colleges" that have governing councils that regulate the profession. The registrants of the profession in the province elect the members of the councils and the colleges receive no government funding. The Ontario government also appoints public members to the councils and pays the public members a per diem. Staff at the colleges are not state employees. Ontario supports title protection, but registrants are not "licensed to practice."[117]

In 1991 the Ontario government implemented the Regulated Health Professions Act (RHPA) which has several unusual components. First, the RHPA applied to all regulated health professions a system of "controlled acts" that replaced exclusive scopes of practice. "Controlled acts are those procedures that, if not done correctly and by a competent person, have a high element of risk."[118] The idea arose because regulators understood that while some activities pose a risk of harm to consumers, many activities are not "intrinsically hazardous."[119] In addition, establishing the system of controlled acts encourages overlapping scopes of practice between professions, as individuals (regulated or unregulated) do not need legislative approval to perform activities that are not listed among the controlled acts.[120] The intent of controlled acts is to increase access to health care for consumers.

Second, the RHPA created the Health Professions Regulatory Advisory Council (HPRAC), which advises the Minister of Health and Long-Term Care on initial regulation of professions, de-regulating professions and other policy matters.[121] The Council is appointed by the Lieutenant Governor and members are selected to "provide breadth of expertise and experience" on health related topics. The members need not be members of a college, but all have experience in the health care industry. HPRAC is funded by the Ministry of Health and Long Term Care; it receives no funding from the colleges.

In addition to the RHPA components, the Health Professions Appeal and Review Board (HPARB) is made entirely of members of the public who are appointed by the government. HPARB offers a process for complainants and licensees who wish to appeal the decisions made by the disciplinary committee of their respective college.[122] HPARB also reviews appeals regarding applications for registration that were denied by a college. HPARB reviews the "*adequacy* of the Complaints Committees' investigations and/or the *reasonableness* of the Committees' decisions."[123] The Board does not have the authority to overturn decisions or impose disciplinary action, but rather examines the process the college followed to arrive at their decision. The Board can uphold the decision; direct the college to investigate the complaint further or make recommendations to the compliance committee.[124]

Outside of the statutory framework, many executive staff at various colleges cooperate with each other voluntarily to form the Federation of Health Regulatory Colleges. The purpose of the Federation is to encourage idea sharing and best practices among the colleges. Participation is voluntary, and some respondents indicated that it was a worthwhile endeavor.

Interviewees' Responses

Interviewees' from colleges, HPRAC and HPARB were sought for input on three main topics: controlled acts, HPRAC and HPARB.

- Most participants were supportive of the system of controlled acts. Many felt that the system effectively facilitated overlapping scopes of practice. However, one concern raised by two respondents was the problem presented by unregulated practice, that is, when a citizen practices as a regulated professional. RHPA ensures title protection for members of the colleges but for those who are not members and do not use a protected title but perform health related services, prosecutorial jurisdiction is unclear.
- Respondents had mostly positive reactions to HPRAC. Three thought that is was a good idea to have a body that is independent from the colleges to do research on specified topics and make recommendations that were outside of the political realm. HPRAC's involvement with scope of practice issues is important, several said, as it keeps the discussion out of the political arena.
- In contrast, two respondents said that because the government appoints all the HPRAC members, there is always a degree of political influence. In addition, HPRAC acts in a strictly advisory capacity, so the Minister of Health and Long Term Care is under no obligation to accept the recommendations, or even to make the recommendations public.
- Opinions about HPARB were generally positive. Most interviewees felt that HPARB serves an important purpose both by creating a forum through which professionals and consumers can assure that they have received due process. One respondent stated that the compliance procedures at her college were gradually refined as a result of the questions members of HPARB ask at each proceeding. In addition, the fact that HPARB's standard of review is "reasonableness" means that decisions by colleges are not under strict scrutiny.
- The mere existence of HPARB is good public relations for the regulatory scheme, said one respondent. Because public members make up HPARB, it is viewed by many as adding a measure of accountability to the college councils, whereas the colleges have the reputation among some as "protecting their own."

APPENDIX D – SURVEYS

Survey One

Administered to board staff, board liaisons or other administrative staff

Does/Is your board…

- have a board
- administered within a larger agency
- board is advisory to another agency/director
- board is composed entirely of members of the regulated profession and public members
- decisions reviewed by agency/commissioner
- profs on interdisciplinary board have informal influence over their professions' proceedings.
- board members appointed by the Governor
- hire their own staff
- appoint an ed/board administrator
- answer inquiries from public/licensees
- share staff with other board/agency
- co-locate with other board/agency
- share administrative services with other boards
- contribute portion funding to another agency/body (admin)
- share space with other board
- conduct rulemaking
- do their own budgeting
- receive complaints
- investigate complaints
- have in house legal representation
- use ag as legal representation
- appeal process for licensee/complainant
- address unlicensed practice
- hold hearings
- discipline licensees
- administer exams
- contract for exam services
- process applications for licensure
- administer renewals
- verify credentials for new licensees
- set qualifications for renewals
- set qualifications for sitting for exam
- define scope of practice (without legislative approval)
- set grounds for discipline
- collect fees
- set fees
- establish, change policy
- require continuing education
- budget built into another agency
- pay for services to other state agencies (AG, Admin, Finance)
- funded fully through fees
- receive general funds
- publish a newsletter to licensees
- other regular activities

Survey Two

Administered to board executive staff.

1. Under my classification scheme, your state is classified as having _____. Does that sound right to you?

2. What outside forces influence the Board? For example, political groups? Professional groups? Consumer groups?

3. Are different occupations treated consistently?

4. Some of our boards have been discussing the fact that requirements for licensure may exclude some groups like racial and ethnic minorities or people for whom English is a second language. Is this a topic of discussion at your board?

5. Is the Board's funding enough to support the effective carrying out of responsibilities?

6. How adequate is the funding for the complaint process?

7. Do Board members receive training? Do you feel that this training is adequate?

8. To whom is your Board accountable?

9. Are there any other ways that a Board member can be censured?

10. How do you resolve scope of practice issues?

11. How do you feel your board's structure supports your mission of public protection?

12. Could you see a different structure supporting that mission more effectively?

13. Is there anyone else I should talk to in your state?

Survey Three

Administered to executive staff at professional associations.

1. On what kinds of occasions do you interact with the board?

2. What is your relationship like with the board?

3. Are there times when you have influence with the board?

4. To what extent is the board's licensure processing timely?

5. Do you perceive that staff are courteous?

6. Do licensees get the information they need quickly and easily?

7. With regards to the complaint process, do licensees get due process in a timely fashion?

8. Do you find that practitioners are aware of the regulatory requirements?

9. Do you think that the criteria for licensure are ever discriminatory against potential practitioners with various barriers?

10. How are disputes between boards regarding scope of practice resolved?

11. What are your thoughts on the board's structure?

APPENDIX E – MODEL STATES, MINNESOTA COMPARISON

This table was compiled to try to make an "apples to apples" comparison between Minnesota and the more consolidated states selected for case study. The "x's" in the rightmost columns indicate the boards in those states that are represented in Minnesota. The data were assembled from various sources. Not all of the information reflects the same time periods.

Table 7. Minnesota Comparison

MN Board/Agency	MN Appropria-tions	MN regulated profes-sionals	MN FTEs	MN Disciplinary actions/year (2001-02 fiscal year)	MN $/Regulated Professional	MN FTEs/1000 Regulated Professionals	MN Disciplinary Actions /1000 Regulated Professionals	WI	MI	IL
Administrative Services Unit	$359,000	-	5.60							
Health Professionals Services Program	$546,000	-	7.00						x	
Chiropractic Examiners	$384,000	3,525	5.00	8	$108.94	1.42	2.27	x	x	x
Dentistry	$922,000	14,423	10.00	7	$63.93	0.69	0.49	x	x	x
Dietetics and Nutrition	$101,000	1,102	0.75	-	$91.65	0.68	-	x		x
Emergency Medical Services Regulatory	$1,132,850	28,000	15.00	2	$40.46	0.54	0.07		x	
Examiners for Nursing Home Administrators	$198,000	859	2.00	-	$230.50	2.33	-	x	x	x
Marriage and Family Therapy	$118,000	755	1.50	1	$156.29	1.99	1.32	x	x	x
Medical Practitioners	$3,498,000	20,000	24.00	65	$174.90	1.20	3.25	x	x	x
Physical Therapy	$197,000	3,407	2.00	5	$57.82	0.59	1.47	x	x	x
Nursing	$2,405,000	89,981	28.00	153	$26.73	0.31	1.70	x	x	x
Optometry	$96,000	947	0.75	-	$101.37	0.79	-	x	x	x
Pharmacy	$1,386,000	15,459	10.50	12	$89.66	0.68	0.78	x	x	x
Podiatric Medicine	$45,000	183	0.50	-	$245.90	2.73	-	x	x	x
Psychology	$680,000	3,623	9.80	9	$187.69	2.70	2.48	x	x	x
Social Work	$1,073,000	9,816	10.30	11	$109.31	1.05	1.12	x	x	x
Veterinary Medicine	$163,000	2,820	1.75	1	$57.80	0.62	0.35	x	x	x
Health Licensing Boards TOTAL	**$12,944,850**	**194,900**	**134.45**	**274**	**$66.42**	**0.69**	**1.41**			

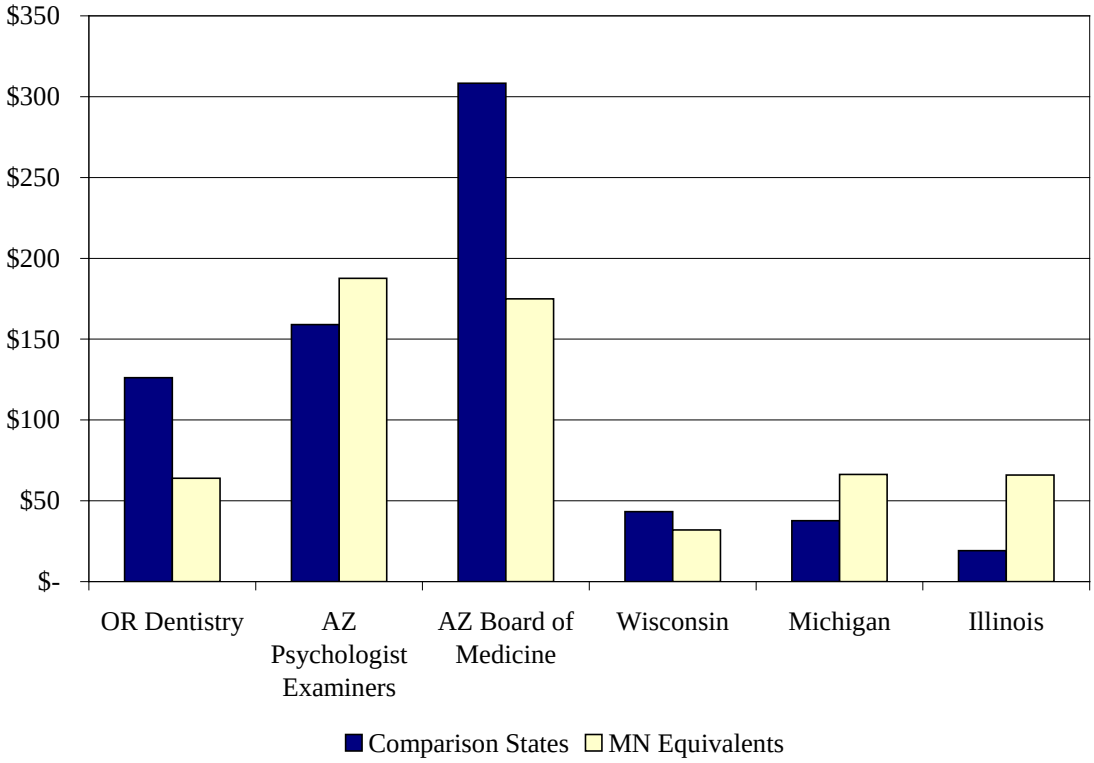
Table 7. Minnesota Comparison										
MN Board/Agency	**MN Appropria-tions**	**MN regulated profes-sionals**	**MN FTEs**	**MN Disciplinary actions/year (2001-02 fiscal year)**	**MN $/Regulated Professional**	**MN FTEs/1000 Regulated Professionals**	**MN Disciplinary Actions /1000 Regulated Professionals**	**WI**	**MI**	**IL**
Board of Accountancy	$577,000	17,195	4.00	N/A	$33.56	0.23	N/A	x		x
Board of Architecture, Engineering, Land Surveying, Landscape	$785,000	16,269	8.00	24	$48.25	0.49	1.48	x		x
Board of Barber Examiners	$127,000	3,025	2.00	10	$41.98	0.66	3.31	x		x
Private Detectives and Protective Agent Services Board	$126,000	300	1.75	12	$420.00	5.83	40.00	x		x
Department of Commerce	$774,000	276,000	14.00	800	$2.80	0.05	2.90	x		
Division of Health Policy and Systems Compliance	$1,322,000	6,435	14.80	77	205.44	2.30	11.97	x		
Grand Total	**$16,655,850**	**514,124**	**173**	**1,197**	**$32.40**	**2,964.96**	**2.41**			

Table 8. Summary*						
	OR Dentistry	**AZ Psychologist Examiners**	**AZ Board of Medicine**	**WI**	**MI**	**IL**
$/Regulated Professionals	$126	$159.00	$308.28	$43.26	$37.71	$19.13
MN Equivalent	$64	$187.69	$174.90	$31.93	$66.27	$65.92
FTEs/1000 Regulated Professionals	1.04	2.45	3.75	0.54	0.32	0.41
MN Equivalent	0.69	2.70	1.20	0.34	0.69	0.66
Disciplinary Actions/1000 Regulated Professionals	10.25	5.51	7.69	4.75	1.12	6.03
MN Equivalent	0.49	2.48	3.25	2.46	1.41	1.56

*The following four pages provide context for the figures in this table. Making cost comparisons can be misleading because of the limitations of the data.

The graph below illustrates the five model representative states compared to the equivalents for Minnesota. The Minnesota figures were calculated by comparing only the boards in Minnesota that regulate similar professionals to those of the model states. For example, the Wisconsin Department of Regulation and Licensing (DRL) regulates not just health professionals, but also interior designers and professional geologists. So to compare the two states, the Minnesota calculations include figures for boards in Minnesota that are roughly equivalent to those at the DRL.

Figure 1. Model Representatives and their Minnesota Equivalents: Budgetary Dollar per Regulated Professional



Many factors influence the annual budget of a department, making it difficult to draw conclusions from Figure 1. For example, the features listed in Table 6 show that Illinois has the lowest ratio of dollars to regulated professionals ($19.13 per regulated professional). Several factors may account for this low rate. First, Illinois regulates more than twice as many professionals (737,674) as does the next largest state, Michigan (352,732), so it is possible that Illinois realizes economies of scale that other states may not. Second, Illinois utilizes in-house legal representation for its compliance matters, which may be less expensive than paying for the state's Attorney General services. Also, the Illinois Department of Professional Regulation does not have an appeals process for licensees or complainants who are dissatisfied with disciplinary decisions, so they avoid costs associated with that process for which other states like Oregon, Arizona and Wisconsin pay. Last, the data does not indicate the variations in statutory requirements or service environments that make the states difficult to compare.

Oregon and Arizona have similar governance structures to that of Minnesota. Figure 1 indicates that Minnesota's Board of Dentistry has substantially lower costs per regulated professional than

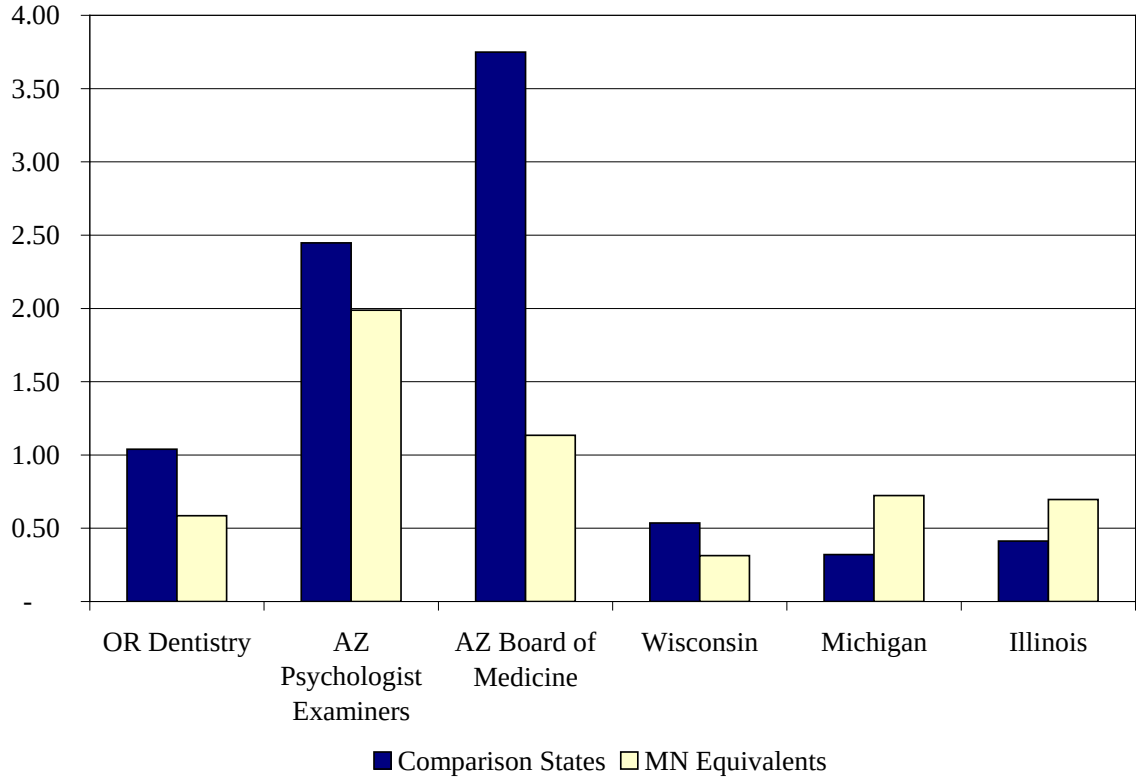
Oregon's Board of Dentistry and the Minnesota Board of Medical Practice had much lower costs than Arizona's Board of Medicine. Costs were closer for Minnesota's Board of Psychology and Arizona's Board of Psychologist Examiners.

As for more consolidated states, Michigan offers the closest comparison to Minnesota because the Michigan Bureau of Health Services (BHS) regulates only health professionals. The cost per regulated professional for BHS is $37.71, while it is $66.27 in Minnesota for comparable health related occupations. Several factors may account for this discrepancy.

- First, the ratio of full time employees to regulated professionals is much lower in Michigan than in Minnesota (0.32 FTEs per 1000 regulated professionals in Michigan, and 0.69 in Minnesota). In part, Michigan's lower staffing levels are due to the current statewide fiscal shortfall, which has left BHS understaffed. It is possible that the lower FTE ratio results in slower processing times for Michigan's initial licensing applications and renewals.
- Secondly, Michigan may have lower costs per regulated professional than Minnesota because it does not fully compensate the Attorney General's office for services rendered on behalf of its boards.
- BHS receives administrative and technical services from the department (CIS) in which it is located. BHS compensates CIS for these services, but because the services are consolidated across several bureaus, they may realize economies of scale that would be impossible for BHS alone.[125]
- Michigan compliance division does not address the unlicensed practice of health professions. This may reduce expenditures for investigations and compliance. However, the Michigan Regulatory Division is required to investigate licensees who have been the subject of three or more malpractice suits, which may raise costs.
- BHS has slightly fewer disciplinary actions (1.12) per 1000 regulated professionals than Minnesota's similar Health Licensing Boards (1.41), which may reduce expenditures for investigations and compliance.

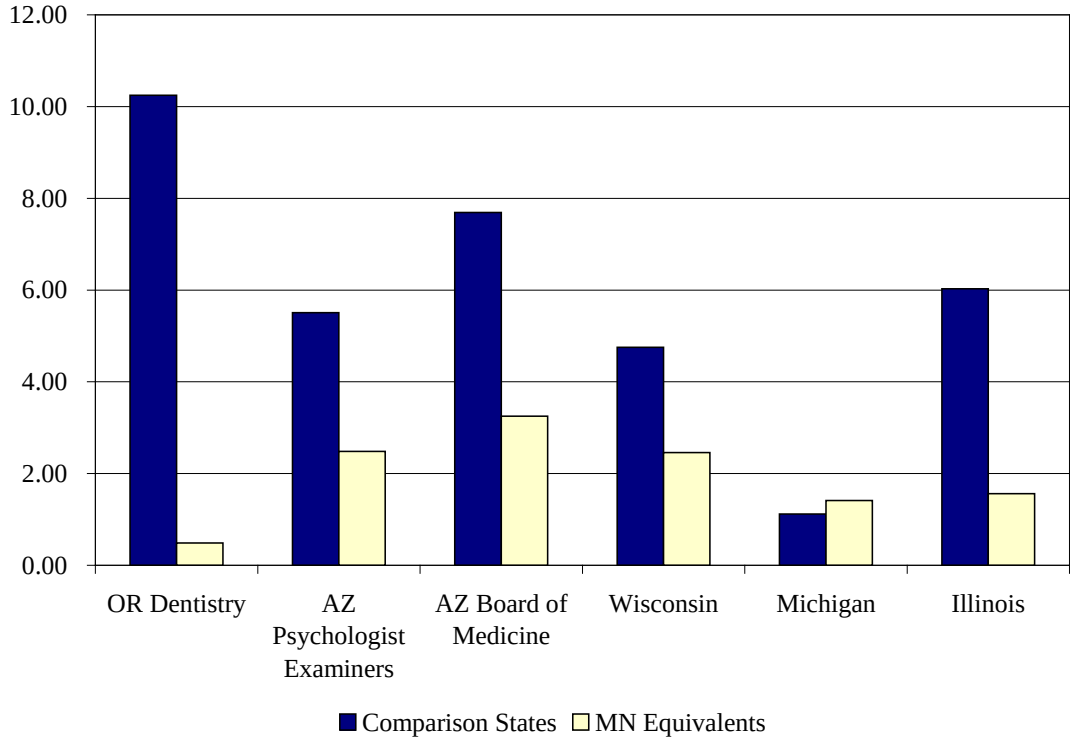
Again, it is important to note that taking costs comparisons at face value can be misleading, especially in light of the fact that detailed cost comparisons of the outcomes of boards in achieving their overall mission are largely unavailable. See "Study Approach and Limitations" for further discussion.

Figure 2. Full Time Employees (FTEs) per 1000 Regulated Professionals



In general, it appears that Minnesota's comparable boards employ fewer FTEs per regulated professional than do boards in other states besides Illinois and Michigan. The fact that Wisconsin's DRL FTE-to-regulated professional ratio is higher than in Minnesota's, calls into question the data's accuracy, given the discussion around the DRL's staffing shortage (see Appendix C – Detailed Case Studies).

Figure 3. Disciplinary Actions per 1000 Regulated Professionals



On the other hand, Figure 2 indicates that the Minnesota boards discipline regulated professionals at a lower rate than most comparable boards in the states selected for case study. This data is subject to question, however, because of the way the data was collected: for Minnesota, only the most conservative notion of "discipline" was used, while this researcher has no way of knowing how other states calculated their disciplinary actions rate.

The following table lists the fees associated with initial licensure and annual renewal for Minnesota. These fees do not generally include the cost of an exam.

Table 9. Minnesota Independent Health Licensing Boards Fees		
Boards	**Initial License Fee**	**Annualized Renewal Fee**
Chiropractic Examiners	$250*	$200
Dentistry	$35-$140	$35-$155
Dietetics and Nutrition	$250-$325	$75
Emergency Medical Services Regulatory Board	$0	$0
Examiners for Nursing Home Administrators	$100	$200
Marriage and Family Therapy	$75-$125	$75-$125
Medical Practitioners	$50-$200	$100-$192
Physical Therapy	$100	$60
Nursing	$105	$43
Optometry	$97	$105
Pharmacy	$20-$180	$20-$180
Podiatric Medicine	$600	$600
Psychology	$125-$250	$125-$250
Social Work	$115-$331	$58-$166
Veterinary Medicine	$125	$100

*Includes exam fee.

APPENDIX F – INTERVIEWS CONDUCTED

Alder, Rob. Chair, Ontario Health Professions Regulatory Advisory Council.

Allen, Ron. Executive Director, Texas State Board of Veterinary Medical Examiners.

Allmendinger, Lisa. Board Member, Michigan Board of Veterinary Medicine.

Anderson, Mary. Scope of Practice Review Committee, Iowa Department of Public Health.

Austin, Dale. Deputy Executive Vice President and Chief Operating Officer, Federation of State Medical Boards.

Babb, Mauralea. Executive Director, Illinois Association for Marriage and Family Therapists.

Barrette, Bruce. Chair, Wisconsin Dentistry Examining Board.

Beaghler, Mike. Program Manager, Arizona Division of Licensing.

Bontrager, Judy. Associate Director of Operations, Arizona Board of Nursing.

Bovbjerg, Randall. Research Analyst, Urban Institute.

Braatz, Patrick. Executive Director, Oregon Board of Dentistry.

Brim, Melanie. Director, Bureau of Health Services, Michigan Department of Consumer and Industry Services.

Carter, Elizabeth. Executive Director, Virginia Department of Health Professions, Board of Health Professions.

Brown, Connie. Oregon Board of Licensed Professional Counselors and Therapists.

Burghardt, Linda. Governmental Affairs Specialist, National Association of Social Workers, Michigan Chapter.

Cassidy, Barry. Executive Director, Arizona Medical Board.

Clabaugh, Gerd. Chief, Internal Operations Division, Iowa Department of Administrative Services.

Condos, Dennis. Chair, Ontario Health Professions Appeal and Review Board.

Confer, Jack. Executive Director, Arizona State Board of Optometry.

Craig, Helen. Illinois Department of Professional Regulation.

Crawford, Lynda. Director of Research and Education Services, National Council of State Boards of Nursing.

Dennik-Champion, Gina. Executive Director, Wisconsin Nursing Association.

Diehl, Amanda. Deputy Executive Director, Arizona Medical Board.

Dooley, Jeffery. Chair, Illinois Board of Athletic Trainers.

Dower, Catherine. Associate Director, Health Law and Policy Project Director, California Workforce Initiative University of California San Francisco, Center for the Health Professions.

Ellis, Gary. Executive Director, Iowa Optometric Association.

Evans, Lynette. Policy Advisor, Regulatory Affairs, Arizona Office of the Governor.

Feinberg, Eugene. Virginia Podiatric Medical Association.

Fisher, Sandra. Executive Director, Oregon Physical Therapy Association.

Ford, Colin. Manager, Government Affairs, Michigan State Medical Society.

Fox, Cheryl. Board Liaison, Illinois Department of Professional Regulation.

Joe Gieck, Board Member, Virginia Board of Physical Therapy and Board Member, Virginia Board of Health Professions.

Fries, David. Executive Director, Iowa Priority.

Grapentine, Mark. Legislative Council, Wisconsin Medical Society. Telephone interview.

Greenleaf, Joyce. Project Leader, Office of Inspector General, U.S. Department of Health and Human Services.

Grill, Becky. Government Relations Chair, Illinois Dental Hygienists' Association.

Harvey, Marcus. Deputy Director, Arizona Board of Psychologist Examiners.

Herbst-Paakonen, Heidi. Executive Director, Arizona Board of Physical Therapy.

Hiendlmayr, Tom. Director, Health Occupations Program, Minnesota Department of Health.

Holt, Tom. Executive Director, Oregon State Pharmacists Association.

Horton, Charles. Administrative Officer, Texas Health Professions Council.

Ingraham, Sharon. Executive Assistant, Oregon Board of Dentistry.

Jacobson, Carol. Director of Health Policy, Public Affairs, Ontario Medical Association.

Kane, Emily. Executive Director, Arizona Veterinary Medical Association.

Kent, Patte. Executive Director, Texas Chiropractic Association.

Kleiner, Morris. Director, Center on Labor Policy, Hubert H. Humphrey Institute of Public Afairs, University of Minnesota.

Kupperman, Gerard. Chair, Wisconsin Hearing and Speech Examining Board.

Diane Lewis. Licensing Division, Bureau of Health Services, Michigan Department of Consumer and Industry Services.

Luhman, Chris. IT Administrator, Minnesota Health Licensing Boards.

Manning, Lucinda. Executive Director, Iowa Board of Nursing.

Mawji, Sheila. Policy Analyst, Ontario Health Professions Regulatory Advisory Council.

McGiffert, Lisa. Senior Policy Analyst on Health Issues, Consumer Union.

McHenry, Karla. Vice President Public Policy and Advocacy, Iowa Medical Society.

McTeague, Dave. Executive Director, Oregon Board of Chiropractic.

Montesano, Deanne. Policy Analyst, Ontario Health Professions Regulatory Advisory Council.

Oetting, Thomas. Iowa Scope of Practice Review Committee.

O'Connell, Dave. Division of Enforcement, Wisconsin Department of Regulation and Licensing.

Paxon, Reed. Acting Assistant Coordinator of Nursing, Illinois Department of Professional Regulation.

Plunkett, David. Executive Director, Oregon Board of Optometry.

Ramsell, Rae. Manager of Licensing, Bureau of Health Services, Michigan Department of Consumer and Industry Services.

Reen, Sandra. Executive Director, Virginia Board of Dentistry and Board of Nursing Home Administrators.

Ridenhouer, Michael. Vice-Chair, Virginia Board of Health Professions.

Ryan, Thomas. Bureau Director, Wisconsin Department of Regulation and Licensing.

Sanders, Tony. Public Information Officer, Illinois Department of Professional Regulation.

Schoeberl, Mark. Former Deputy Director, Iowa Department of Public Health.

Scott Russell, Elizabeth. Executive Director, Virginia Board of Pharmacy.

Siskind, Gail. Director, Investigations and Hearings, College of Nurses of Ontario.

Smith, Sandra. Executive Director, Texas Board of Chiropractic Examiners.

Smith, Valerie. Associate Director of Nursing Practice, Arizona Board of Nursing.

Swankin, David. President, Citizen Advocacy Center.

Terranova, Tim. Consumer Assistant, Maine Board of Licensure in Medicine.

Thomas, Kathy. Executive Director, Board of Nurse Examiners for the state of Texas.

Treffert, Darold. Former Chair, Wisconsin Medical Examining Board.

Ulieru, Robert. Director, Regulatory Division, Bureau of Health Services, Michigan Department of Consumer and Industry Services.

Valde, Jill. Iowa Scope of Practice Review Committee.

Vanfleet, Doug. Executive Officer, Oregon Board of Examiners of Licensed Dieticians.

Walsh, Anne. Executive Director, Oregon Board of Naturopathic Examiners.

Wand, Hal. Executive Director, Arizona State Board of Pharmacy.

Wilson, Susan. Director, Oregon Health Licensing Office.

Worrad, Deborah. Registrar, College of Massage Therapists of Ontario.

Worth, Barbara. Registrar, College of Occupational Therapists of Ontario.

Zepp, William. Executive Director, Oregon Dental Association.

Zychowski, Deanna. Board Liaison, Wisconsin Department of Regulation and Licensing.

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[2] Here, social capital is defined as "features of social organization, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit." Putnam, Robert D. "The Prosperous Community; Social Capital and Public Life." *The American Prospect.* http://www.prospect.org/print/V4/13/putnam-r.html (viewed Nov. 7, 2003).

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[5] Swankin, David. President, Citizen Advocacy Center. Telephone interview. Aug. 20, 2003.

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[7] Texas Health and Human Services Commission. "Report on Texas Department of Health Regulatory Programs; Recommendations for Consolidating, Restructuring, or Moving Health-Related Regulatory Programs" at 33 Dec. 15, 2000.

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[12] Swankin, David. President, Citizen Advocacy Center. Telephone interview. Aug. 20, 2003; Greenleaf, Joyce. Project Leader, Office of Inspector General, U.S. Department of Health and Human Services. Telephone interview. Aug. 25, 2003.

[13] The Iowa Health Regulation Task Force recommended to the Legislature that the independent health boards "administratively cluster" in the Bureau of Professional Licensure in order to reduce duplicative investigations and administrative staffing. The Legislature did not follow this recommendation. Health Regulation Task Force. "Health Professionals Committee Meeting Minutes." Des Moines, Iowa: 1996.

[14] Texas Health and Human Services Commission. "Report on Texas Department of Health Regulatory Programs; Recommendations for Consolidating, Restructuring, or Moving Health-Related Regulatory Programs" at 9. Dec. 15, 2000; Oregon Department of Administrative Services, Budget and Management Division. *Regulated Professional Occupations*. Management Study at 29. 1997.

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[17] California State. Assembly Committee on Consumer Protection, Governmental Efficiency and Economic Development. Bill No. AB 3164. Sacramento, California: May 7, 1996.

[18] The Texas Sunset Advisory Commission designed a useful "Sunset Occupational Licensing Model" to help boards and legislators structure boards' services and governance. Texas Sunset Advisory Commission. "Sunset Occupational Licensing Model." http://www.sunset.state.tx.us/licensemodel05.pdf (viewed Nov. 14, 2003).

[19] Shimberg, Benjamin. *Occupational Licensing: a Public Perspective*. Center for Occupational and Professional Assessment, Educational Testing Service. 1980 at 191-192.

[20] Schmitt, Kara and Benjamin Shimberg. *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask.* Council on Licensure, Enforcement and Regulation. Lexington, KY: 1996.

[21] The Director of the Department of Professional Regulation appoints most board members. However, the governor appoints the members of the following boards: Medical Disciplinary Board, Medical Licensing Board, State Board of Pharmacy, Physician Assistant Advisory Committee, Nursing Home Administrators Licensing and Disciplinary Board, and Advanced Practice Nursing Board. Illinois Department of Professional Regulation. "Biennial Report 2000-2001." 2002.

[22] Some boards have an Inter-Agency Services Agreement with the Department of Administration to provide some administrative services such as payroll, budgeting, accounting and a phone bank. Confer, Jack, Executive Director, Arizona Board of Optometry. Personal communication. Sept. 10, 2003.

[23] The Arizona boards must contribute ten percent of their revenues to the state's general fund.

[24] The Wisconsin boards must contribute ten percent of their revenues to the state's general fund.

[25] The Director of the Bureau can write rules to manage the administration of the boards.

[26] A Disciplinary Subcommittee, made up of members of the Board, makes decisions regarding discipline of licensees. The Director of the Bureau can order a summery suspension of a license when the Board is not able to meet soon, and there is evidence that the licensee poses an imminent threat. Michigan Statutes 333.16233.

[27] The Bureau is also obliged to investigate licensees who have sustained "three or more malpractice settlements, awards, or judgments against a licensee in a period of five consecutive years or one or more malpractice settlements, awards, or judgments against a licensee totaling more than $200,000.00 in a period of five consecutive years" Michigan Statutes 333.16231.

[28] The Attorney General represents the Department in cases where a board decision is appealed to the courts.

[29] Licensees may appeal to the state's Office of Administrative Hearings.

[30] Sanders, Tony, Public Information Officer. Illinois Department of Professional Regulation. Personal communication. Oct. 9, 2003.

[31] Hearings are held by the Office of Administrative Hearings, for which the boards must compensate the Office.

[32] The Michigan Department of Consumer and Industry Services has a separate bureau that holds hearings.

[33] The Michigan Department of Consumer and Industry Services collects and processes fees; the Bureau of Health Services reimburses CIS for this service.

[34] The original licensing fees are set in statute, but the Bureau of Health Services can raise fees based on a cost of living increase.

[35] "The rationale for applying a 10% transfer requirement is to reimburse the general fund for the indirect costs of state services that are provided to these agencies." Wisconsin Legislative Fiscal Audit Bureau. "GPR-Earned redited from Criminal Background Check Fees (R&L)." Paper #793. May 2, 2001 http://www.legis.state.wi.us/lfb/2001-03budget/2001-03budgetpapers/793.pdf (viewed Nov. 5, 2003).

[36] It takes four weeks to process fingerprints.

[37] Cheryl Fox. Board Liaison, Michigan Bureau of Health Services. Personal Communication. Oct. 9, 2003.

[38] O'Connell, Dave. Division of Enforcement, Wisconsin Department of Regulation and Licensing. Personal communication. Oct. 9, 2003.

[39] Case must be resolved within twelve months of being opened. The Compliance Division may take 60 to 90 days to initiate a case. Sherri Cooper Johnson, Complaints and Allegation Division, Michigan Department of Consumer and Industry Services. Personal Communication. Oct. 8, 2003.

[40] Brim, Melanie. Director, Bureau of Health Services, Michigan Department of Consumer and Industry Services. Personal Communication. Oct. 8, 2003.

[41] Graddy, Elizabeth and Michael B. Nichol. "Structural Reforms and Licensing Board Performance." *American Politics Quarterly* 18 (1990): at 389.

[42] Minnesota Office of the Legislative Auditor. *Occupational Regulation; A Program Evaluation Report* at 86. 1999 available at http://www.auditor.leg.state.mn.us/ped/pedrep/9905sum.pdf (viewed Aug. 15, 2003).

[43] These findings directly contradicted their hypothesis. Graddy, Elizabeth and Michael B. Nichol. "Structural Reforms and Licensing Board Performance." *American Politics Quarterly*. 18 (1990): 389.

[44] Id at 392.

[45] Id at 394.

[46] The AAG used three separate data sources on disciplinary actions. Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 at 9. 1995.

[47] Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 at 34. 1995.

[48] Conant, James K. "Executive Branch Reorganization in the States, 1965 to 1987." *Public Administration Review* 48:5 (Sept./Oct. 1988) 892-902.

[49] Texas Health and Human Services Commission. "Report on Texas Department of Health Regulatory Programs; Recommendations for Consolidating, Restructuring, or Moving Health-Related Regulatory Programs" at 8. Dec. 15, 2000.

[50] Crawford, Lynda, PhD, RN, CAE. Director of Research and Education Services, National Council of State Boards of Nursing. Telephone interview. Oct. 3, 2003.

[51] For example, the Federation of State Medical Boards believes that independent boards are preferable to consolidated organizations. Austin, Dale. Deputy Executive Vice President and Chief Operating Officer, Federation of State Medical Boards. Telephone interview. Aug. 15, 2003.

[52] One expert commented that consolidating boards may not result in a large cost savings for all licensees, however, as larger boards end up subsidizing smaller boards. Fries, David. Executive Director, Iowa Priority. Telephone interview. Aug. 14, 2003. *See also* Texas Comptroller of Public Accounts. "Limited Government, Unlimited Opportunity – Consolidate Health and Human Service Agencies to Reduce Cost and Improve Service Delivery." January 2003 available at http://www.window.state.tx.us/etexas2003/gg03.html (viewed Oct. 17, 2003). *See also* Minnesota Office of the Legislative Auditor. *Occupational Regulation; A Program Evaluation Report*. 1999 available at http://www.auditor.leg.state.mn.us/ped/pedrep/9905sum.pdf (viewed Aug. 15, 2003).

[53] Swankin, David. President, Citizen Advocacy Center. Telephone interview. Aug. 20, 2003.

[54] Graddy, Elizabeth and Michael B. Nichol. "Structural Reforms and Licensing Board Performance." *American Politics Quarterly*. 18 (1990): at 389-90.

[55] "Contrary to what reorganization advocates project, executive reorganization seldom saves the state a substantial amount of money for several reasons:

- Many agencies, boards and commissions that are eliminated tend to have miniscule budgets.
- Initial savings from reorganization, if any, are likely to be reinvested.
- New programs and new laws will be initiated during the reorganization process, resulting in higher spending.
- Inflation and cost-of-living adjustments for state workers cancel out most of the cost savings resulting from reorganization…

The Council of State Governments. *State Trends Forecasts*. 1:1 Dec. 1992 at 2-3.

[56] Graddy, Elizabeth and Michael B. Nichol. "Structural Reforms and Licensing Board Performance." *American Politics Quarterly*. 18 (1990): at 378-379.

[57] Dower, Catherine. Associate Director, Health Law and Policy Project Director, California Workforce Initiative University of California San Francisco, Center for the Health Professions. Telephone interview. Sept. 4, 2003.

[58] Id.

[59] Public Citizen. "Ranking of State Medical Board Serious Disciplinary Actions in 2002." http://www.citizen.org/publications/release.cfm?ID=7234 (viewed Oct. 22, 2003). The report explains,

> These data again raise serious questions about the extent to which patients in many states with poorer records of serious doctor discipline are being protected from physicians who might well be barred from practice in states with boards that are doing a better job of disciplining physicians. It is extremely likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

[60] For example, a Minnesota Department of Health report stated, "Disciplinary information reported by health-related licensing boards does not adequately represent the job they are doing in protecting the public from unfit practitioners." Minnesota Department of Health. *Health Occupations Regulation and Health Care Reform*. St. Paul, MN: 1995. *See also* Meyer, Charles R., "Policing the Medical Profession." *Minnesota Medicine*. 83: November 2000 available at http://www.mnmed.org/Protected/00MNMED/0011/Meyer.html (viewed Aug. 25, 2003).

> Any physician who has participated in evaluating another physician's competence knows that these issues are seldom so clear-cut. Most questionable physicians are not psychopaths. Most questionable clinical performance is not blatant malpractice. Most inquiries into physician performance are judgment calls where instant-replay hindsight can give a deceptively clear view of what was hazy when the decision was made. And Wolfe's book and Web site reduce the analysis of board performance to sports-page statistics that assume that an undiscovered mass of incompetent physicians exists so the "good" boards find the most offenders and have the most sanctions.

[61] The Virginia Board of Health Professions (see "Virginia") is currently working on a project to provide sanctioning guidelines to the various health boards. Carter, Elizabeth, PhD. Executive Director, Virginia Board of Health Professions. Telephone Interview Sept. 30, 2003.

[62] Oregon Department of Administrative Services, Budget and Management Division. *Regulated Professional Occupations*. Management Study. 1997 at 29.

[63] Crawford, Lynda, PhD, RN, CAE. Director of Research and Education Services, National Council of State Boards of Nursing. Telephone interview. Oct. 3, 2003.

[64] Graddy, Elizabeth and Michael B. Nichol. "Structural Reforms and Licensing Board Performance." *American Politics Quarterly*. 18 (1990): at 394.

[65] Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 1995 at 9.

[66] Finocchio L J, Dower C M, McMahon T, Gragnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995 at vii.

[67] Dower, Catherine. Associate Director, Health Law and Policy Project Director, California Workforce Initiative University of California San Francisco, Center for the Health Professions. Telephone interview. Sept. 4, 2003. The restriction of emerging alternative professions affects some communities more than others. For example, members of new immigrant communities may feel more comfortable seeking out care from practitioners who speak their language or may not be part of the insurance system.

[68] Finocchio L J, Dower C M, McMahon T, Gragnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995 at 9-10.

[69] Finocchio L J, Dower C M, McMahon T, Gragnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995 at 14.

[70] Kany, Judy C. and Saskie D. Janes. "Improving Public Policy for Regulating Maine's Health Professionals." *Report to the governor and the Maine Legislature prepared for Medical Care Development, Inc., Maine Health Professions Regulation Project*. Augusta, Maine: 1997 at 48.

[71] Finocchio LJ, Dower CM, Blick NT, Gragnola CM and the Taskforce on Health Care Workforce Regulation. "Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation." San Francisco, CA: Pew

Health Professions Commission. Oct. 1998 at 14. The authors went on to say that such an oversight entity should not "micro-manage" the operations of the boards, but rather "establish and enforce overall policy goals."

[72] Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 1995 at 9.

[73] Dower, Catherine. Associate Director, Health Law and Policy Project Director, California Workforce Initiative University of California San Francisco, Center for the Health Professions. Telephone interview. Sept. 4, 2003.

[74] Evidence regarding public membership on boards is mixed. There is no clear relationship between the presence or number of public members and the number of disciplinary actions taken by the boards. Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 1995 at 7-8. The Pew Commission recommends that the public members of boards be trained adequately, as representing the public is not always a self-evident responsibility. Finocchio L J, Dower C M, McMahon T, Gragnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995 at 15. For more information, *see* Citizen Advocacy Center, http://www.cacenter.org/.

[75] Finocchio LJ, Dower CM, Blick NT, Gragnola CM and the Taskforce on Health Care Workforce Regulation. "Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation." San Francisco, CA: Pew Health Professions Commission. Oct. 1998 at i.

[76] Terranova, Tim. Consumer Assistant, Maine Board of Licensure in Medicine. Telephone interview. Oct. 10, 2003. In addition, Mr. Terranova commented that when he speaks to public groups, many are less interested in understanding how they can file a complaint in the future than in information they can gather on their current doctor, like background, specialty and schooling.

[77] In Texas, the Board of Medical Examiners requires licensees to post plaques in their offices with information on the licensing board. The Texas board also furnishes information on disciplinary actions to public libraries. Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 1995 at 21.

[78] Minnesota Department of Health, Health Policy and Systems Compliance Division. *Rehabilitation Therapy Board Study*. 1999 at 5.

[79] Texas Legislature, House Bill 2985. 2003 available at http://www.capitol.state.tx.us/tlo/78R/billtext/HB02985F. htm (viewed Sept. 25, 2003). Consumers Union. "What the Governor Didn't Tell Us About Session." Austin American-Statesman. June 16, 2003 http://www.statesman.com/opinion/content/auto/epaper/editions/today/editorial _e3ceb1e b42d7025100f1.html (viewed August 19, 2003).

[80] Maine Board of Licensure in Medicine. "Best of Boards." *Notes from Your Licensing Board*. Fall 2002. www.docboard.org/me/2002FallNewsletter.doc (viewed Oct. 10, 2003). Terranova, Tim. Consumer Assistant, Maine Board of Licensure in Medicine. Telephone interview. Oct. 10, 2003.

[81]Some argue against the regulation occupations in general:

- "These regulations typically raise the price of services without significantly raising service quality – and indeed, in many instances regulation appears to lower the quality of services consumers buy.
- Reduced competition. The theory is that by excluding some providers of a service from the market, regulations reduce competition and form a kind of 'cartel' in which service providers can afford to charge high prices without fear of losing customers."
- Regulation can negatively affect quality because: consumers will substitute un-regulated services for regulated services; consumers will avoid seeking treatment that is not urgent; and over-training (professionals sometimes perform tasks which could be competently performed by less-trained staff).

Hood, John. "Does Occupational Licensing Protect Consumers?" *The Freeman* 42: 1992. *See also* Federal Reserve Bank of Richmond, Betty Joyce Nash. "May I See Your License Please?" *Region Focus* available at http://www.rich.frb.org/pubs/regionfocus/summer03/license.html (viewed Nov. 14, 2003).

[82] O'Neil, EH, and the Pew Health Professions Commission. "Pew Health Professions Commission." San Francisco, Calif.: Dec. 1998 at 84.

[83] Kleiner, Morris, PhD. Director, Center on Labor Policy, Hubert H. Humphrey School of Public Affairs. Personal interview. Aug. 12, 2003.

[84] McGiffert, Lisa. Senior Policy Analyst on Health Issues, Consumer Union. Telephone interview. Oct. 6, 2003.

[85] Finocchio LJ, Dower CM, Blick NT, Gragnola CM and the Taskforce on Health Care Workforce Regulation. "Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation." San Francisco, CA: Pew Health Professions Commission. Oct. 1998 at 22-23.

[86] Kleiner, Morris and Robert Kuderle. "Does Regulation Affect Economic Outcomes? The Case of Dentistry." *The Journal of Law and Economics* 43: 547-582 (2000) at 549.

[87] Swankin, David. President, Citizen Advocacy Center. Telephone interview. Aug. 20, 2003.

[88] Oregon Department of Administrative Services, Budget and Management Division. *Regulated Professional Occupations*. Management Study. 1997.

[89] McTeague, Dave, Executive Director of Oregon State Board of Chiropractic Examiners. Telephone communication. Sept. 9, 2003. *See also* Oregon Statutes. Chapter 182.456-182.472. http://landru.leg.state.or.us/ors/182.html (viewed Oct. 30, 2003).

[90] Oregon Statute. Chapter 691.485. http://www.leg.state.or.us/ors/691.html (viewed Oct. 30, 2003).

[91] Currently ten boards reside within the Health Licensing Office, including Board of Athletic Trainers, Body Piercing Licensing Program; Board of Cosmetology; Board of Direct Entry Midwifery; Board of Denture Technology; Electrologists, Permanent Color Technicians and Tattoo Artists Licensing Program, Hearing Aid Dealer Licensing Program, Sanitarians Registration Board, Respiratory Therapist Licensing Board. Health Licensing Office. "About the Health Licensing Office." http://www.hdlp.hr.state.or.us/about.htm (viewed Sept. 4, 2003).

[92] The Department directly regulates the Midwife Licensing Program, without the advice of a board. Auditor General, "The Health Regulatory System." Report to the Arizona Legislature. Report #95-13, at 1, 1995.

[93] Confer, Jack, Executive Director, Arizona State Board of Optometry. Personal communication. Sept. 10, 2003.

[94] Arizona Auditor General, "The Health Regulatory System; Report to the Arizona Legislature." Report #95-13 1995.

[95] Wand, Hal, Executive Director, Arizona State Board of Pharmacy. Telephone communication. Sept. 10, 2003.

[96] Evans, Lynette. Policy Advisor for Regulatory Affairs, Office of the governor, State of Arizona. Telephone communication. Sept. 23, 2003.

[97] Wand, Hal, Executive Director, Arizona State Board of Pharmacy. Telephone communication. Sept. 10, 2003.

[98] Wisconsin Department of Regulation and Licensing. "Biennial Report 1999-2001." 2001.

[99] Wisconsin statute. 440.01 (http://www.legis.state.wi.us/statutes/Stat0440.pdf).

[100] Braatz, Patrick. Executive Director, Oregon Board of Dentistry and former Bureau of Health Professions Director, Wisconsin Department of Regulation and Licensing. Telephone Communication. Sept. 12, 2003.

[101] Brim, Melanie. Director, Bureau of Health Services, Michigan Department of Consumer and Industry Services. Telephone Communication. Oct. 8, 2003.

[102] Uliero, Robert. Director, Regulatory Division. Telephone communication. Oct. 2, 2003.

[103] The Bureau of Health Services does not compensate the Attorney General's Office fully for these services.

[104] These boards include the Medical Disciplinary Board, Medical Licensing Board, State Board of Pharmacy, Physician Assistant Advisory Committee, Nursing Home Administrators Licensing and Disciplinary Board, and Advanced Practice Nursing Board. Illinois Department of Professional Regulation. *Biennial Report 2000-2001*. Springfield, IL: 2002.

[105] Texas Health Professions Council, "Annual Report." Feb. 1, 2003. Available at http://www.hpc.state.tx.us/HPC%20Anual%20Report.pdf (viewed Sept. 19, 2003).

[106] Texas Statutes. § 101 "Composition of Council." http://www.capitol.state.tx.us/statutes/oc/oc0010100.html#top (viewed Sept. 19, 2003). The governor's office rarely participates actively, however.

[107] Texas Statutes. § 101 "Composition of Council." http://www.capitol.state.tx.us/statutes/oc/oc0010100.html#top (viewed Sept. 19, 2003); Smith, Sandra. Executive Director, Texas Board of Chiropractic Examiners. Telephone communication. Oct. 1, 2003.

[108] Texas Health Professions Council. "Annual Report." Feb. 1, 2003 available at http://www.hpc.state.tx.us/HPC%20Anual%20Report.pdf (viewed Sept. 19, 2003).

[109] See, for example Texas Board of Chiropractic Examiners. *Sunset Self-Evaluation Report*. Austin, TX: Aug. 2003 at 37.

[110] Virginia Department of Health Professions. "Board of Health Professions, Frequently Asked Questions." http://www.dhp.state.va.us/bhp/bhp_faq.htm viewed Sept. 19, 2003.

[111] Minnesota Office of the Legislative Auditor. *Occupational Regulation; A Program Evaluation Report*. 1999 available at http://www.auditor.leg.state.mn.us/ped/pedrep/9905sum.pdf (viewed Aug. 15, 2003) at 83.

[112] Iowa Scope of Practice Review Committee. *Final Report of the Extended Pilot Project.* Iowa Department of Public Health Jan. 2002 at 4.

[113] Id at 6.

[114] Id.

[115] Id.

[116] Schoeberl, Mark. Former Deputy Director, Iowa Department of Public Health. Telephone interview. Nov. 13, 2003.

[117] Health Professions Regulatory Advisory Council. "Adjusting The Balance: A Review of the Regulated Health Professions Act: Report to the Minister of Health And Long-Term Care." March 2001 http://www.hprac.org/downloads//fyr/RHPAReport.pdf (viewed Sept. 5, 2003) at 2.

[118] Health Professions Regulatory Advisory Council. "Adjusting the Balance: A Review of the Regulated Health Professions Act: Report to the Minister of Health and Long-Term Care." March 2001. http://www.hprac.org/downloads//fyr/RHPAReport.pdf (viewed Sept. 5, 2003). Controlled acts include:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissues below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surface of the teeth, including the scaling of teeth.
3. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
4. Setting or casting a fracture of a bone or a dislocation of a joint.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger
   - beyond the external ear canal
   - beyond the point in the nasal passages where they normally narrow,
   - beyond the larynx,
   - beyond the opening of the urethra,
   - beyond the labia majora,
   - beyond the anal verge, or
   - into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act (i.e. RHPA).
8. Prescribing, dispensing, selling or compounding a drug as defined in subsection 117 (1) of the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response (RHPA, section 27).

[119] Health Professions Regulatory Advisory Council. "Adjusting The Balance: A Review of the Regulated Health Professions Act: Report to the Minister of Health And Long-Term Care." March 2001 http://www.hprac.org/downloads//fyr/RHPAReport.pdf (viewed Sept. 5, 2003) at 19. The Health Professions Legislation Review explained the rationale for the controlled acts approach as follows:

> The model we recommend is based on the principle that the sole purpose of professional regulation is to protect the public interest. We believe that regulation of scope of practice is necessary because it is evident that some of the activities performed by health care providers pose a risk of harm if unqualified persons perform them. However, it is equally true that some health care services are not intrinsically hazardous. We believe that the public should have freedom to choose the caregivers from whom it obtains those services that are not unduly hazardous. We believe that the existing regulatory model – both in principle and how it has been applied – inadequately protects the public. Moreover, we believe it has undesirable effects on the health care system. In particular, it discourages flexibility and resists innovation in the provision of health services.

[120] Health Professions Regulatory Advisory Council. "Sunrise/Sunset and Changes in Scope of Practice Criteria Review: An HPRAC Discussion Paper." June, 2003 http://www.hprac.org/downloads/criteriareview/HPRAC-DiscussionPaper-May30-03.pdf (viewed Sept. 5, 2003) at 6.

> Any profession seeking regulation under the RHPA is seeking admittance into a regulatory regime which is premised upon overlapping scopes of practice. Implicit in this mechanism of overlapping scopes of practice is the idea of collaboration between health care providers. Overlapping scopes of practice also mean that collaboration is not dependent upon delegation to occur.

[121] Ministry of Health and Long Term Care. "Health Professions Regulatory Advisory Council." http://www.health.gov.on.ca/english/public/program/pro/hprac.html (viewed Sept. 22, 2003). "The Health Professions Regulatory Advisory Council provides ongoing advice to the Minister of Health and Long-Term Care on:

- whether unregulated professions should be regulated;
- whether regulated professions should no longer be regulated;
- suggested amendments to the Act, a health profession Act, or a regulation under the Act;
- matters concerning the quality assurance programs undertaken by colleges; and
- any matter relating to the regulation of health professions referred to it by the Minister.

The council will also be responsible for monitoring each college's patient relations program and advising the Minister about its effectiveness."

[122] An all-public review board was established before the RHPA, but under the Act, it was given its current title. Worrad, Deborah. Registrar, College of Massage Therapists of Ontario. Telephone communication. Sept. 24, 2003.

[123] Id (emphasis in original).

[124] Ontario Health Professions Appeal and Review Board. *2002 Annual Report*. Toronto, Ontario: 2003 at 3.

[125] CIS provides human resources services and staff, media, internal audit and legislative affairs functions for the Bureau. These services are paid for by BHS. Additional expenditures are made for the Bureau of Hearings, administrative services (such as support in budget, financial, procurement and office services for CIS), and technical support (through the Department of Information Technology). Expenditures are also made to the Department of Management and Budget and Civil Services for human resources, financial, record management and other services. Lewis, Diane. Manager, Policy Administration, Health Licensing Division. Bureau of Health Services, Consumer and Industry Services. Email communication. Nov. 6, 2003.