**APPENDIX 1**

# REGULATING, DE-REGULATING AND CHANGING SCOPES OF PRACTICE IN THE HEALTH PROFESSIONS

## A JURISDICTIONAL REVIEW

**A REPORT PREPARED FOR THE HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL (HPRAC)**

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## APPENDICES

**ACRONYM REFERENCE LIST**

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|---|---|
| ***AHPA*** | *Health Professions Act, 1999*, (Alberta) |
| ***BCHPA*** | *Health Professions Act, 1999* (British Columbia) |
| **CLEAR** | Council on Licensure, Enforcement and Regulation |
| **HPAB** | Health Professions Advisory Board (Alberta) |
| **HPC** | Health Professions Council (British Columbia) |
| **HPPC** | Health Professions Procedure Code |
| **HPLR** | Health Professions Legislative Review |
| **HPRAC** | Health Professions Regulatory Advisory Council or Advisory Council |
| **MOHLTC** | Ministry of Health and Long-Term Care |
| ***RHPA*** | Regulated Health Professions Act, 1991 |

## EXECUTIVE SUMMARY

The regulation of professions by governmental means, whether health or other, is an increasingly complex and polymorphic reality in terms of not only legislative schemes, but also policy choices, which include considerations of: economics, politics, public interest vs. professional interest, and public health, safety and welfare issues. The complexity is further enhanced from a comparative perspective by the number of individual state actors which regulate health professions. If one considers the United Kingdom, Canada, and the United States, the number of state actors is some 63 legislative bodies ranging from federal/national to provincial and state jurisdictions. In addition, while the number of state actors is not insignificant, the picture is further complicated when one considers the number of regulated health professions that are actually regulated within each jurisdiction, a number in the hundreds if not thousands.

The Advisory Council directed its legal counsel and staff to prepare this background report in order to inform HPRAC's review and revision of its policies and procedures with regards to requests for regulation/de-regulation and requests for changes in scope of practice for health professions.

After a review and comparative analysis of Canadian, American and British jurisdictions, this Report has identified the following as among the emerging trends and issues with respect to regulation/de-regulation and changes in scope of practice:

- emergence of Telemedicine/cybermedicine and their effect on a profession's scope of practice;
- increased interest in facilitating collaborative scopes of practice;
- "Sunset" review of regulated professions;
- economic issues related to the cost/benefit analysis of regulation, evaluation of costs of regulation to professions, consumers and taxpayers and system efficiencies;
- importance of Public Interest principles and continuing problems defining it;
- changing practice environment due to evolutions in education and accreditation standards based upon that education;
- regulation of a profession centered upon efficacy of a profession's treatment modalities and its relationship to harm;
- regulatory theory incorporating principles of least regulation possible, and multiple modes of regulation raises question of whether uniform/omnibus regulatory regimes are possible or advisable.

The Report offers no conclusions with respect to these trends and issues, but rather identifies them as a means to further the Advisory Council's discussion as it moves forward to revise two key policy documents.

## INTRODUCTION, PURPOSE AND SEARCH METHODOLOGY

### INTRODUCTION AND PURPOSE

The purpose of this paper is to provide a contextual background to consider the review of HPRAC's criteria for Regulation/De-regulation and Changes in Scope of Practice of Health Professions. Divided into four parts, the paper will first set out, in broad terms, a number of general themes associated with professional regulation. In addition, it will also identify a variety of regulatory models used in the regulation of health professions to allow Ontario's model to be seen in a comparative context. In the second part, it will explore issues surrounding the Regulation/De-regulation process. The third part will consider issues associated with requests for changes in scope of practice. Finally, the paper will conclude with a number of observations dealing with emerging trends and issues related to requests for regulation/de-regulation and changes in scope of practice.

The regulation of health professions by governmental actors is an increasingly complex and polymorphic reality in terms of not only legislative schemes, but also policy choices, which include considerations of: economics, politics, public interest vs. professional interest, and public health, safety and welfare issues. The complexity of analysis is further enhanced from a comparative perspective by the number of individual state actors which regulate health professions. If one considers the United Kingdom, Canada, and the United States, the number of state actors is some 66 legislative bodies ranging from federal/national to provincial, territorial, and state jurisdictions. In addition, while the number of state actors is not insignificant, the picture is further complicated when one considers the total number of regulatory bodies and regulated health professions that are actually regulated within each jurisdiction, a number in the hundreds if not thousands.

In order to bring some cohesion to the following analysis, the discussion will focus upon two levels: (1) substantive policy; and (2) process/procedure. The substantive policy discussion will focus on answering three basic questions: why; when; and what. The process/procedure discussion will attempt to answer two basic questions: who; and how. Because of the comparative nature of the analysis, "where" will be addressed at both levels. Throughout the discussion, Ontario's model will be expounded and compared to other jurisdictions.[1] By keeping the focus upon the "why, when, what, who, how and where" of regulation, it is the intention of this paper to: (1) provide the reader with a basic understanding of the background of, and the key issues associated with, requests for regulation/de-regulation and changes in scope of practice; and (2) to do so in such a manner that helps to place Ontario's *Regulated Health Professions Act* regime into comparative perspective.

[1] Because of the number of possible jurisdictions that could be considered, in order to keep this paper focused, the following jurisdictions have been chosen for review purposes: Canada; United States; and the United Kingdom.

## SEARCH METHODOLOGY

The authors conducted a focused search of the literature and the Internet as well as an extensive review of relevant policy documents, case law, commentary and legal databases:

- A review of the literature from 1990 to the present was conducted using the search capabilities of Health Search, a health information research service operating out of the University Health Network. A listing of the keywords and search strategy used can be found in Appendix A.

- An extensive search of the Internet was conducted using the Lycos and Google search engines. A listing of the keywords and search strategy used can be found in Appendix B.

- A search was also conducted on the legal databases of QuickLaw and Lexis Nexis in order to obtain the most relevant legal information available. Details of the keywords and search strategy used can be found in Appendix C.

## PART I - REGULATORY THEMES – MODELS OF REGULATION

The purpose of this Part is to set out, in broad terms, a number of general themes associated with the regulation of health professionals, to identify a continuum of regulatory models, and to set those themes in a comparative context. As in any comparative analysis,[2] a number of questions present themselves for consideration. For example, what are the various modes and orders used to regulate health professions? What does "regulation" mean? Is regulation achieved through "self-regulation" or through other means such as direct regulation by state agency? What constitutes "self-regulation"? Are there common terms of regulation as between the various regulatory regimes? These and other questions will be considered within the comparative analytical frameworks of substantive policy and process/procedure outlined in the Introduction.

### I. SUBSTANTIVE POLICY

As previously indicated, the substantive policy discussion will focus on answering three basic questions: why; when; and what.

### Why regulation at all?

From a historical perspective, the "why" of modern health profession regulation began in the late 19th/early 20th Century with the emergence of the state regulation of medicine. To prevent the harm associated with dangerous "medical practice" states enacted legislation to regulate those who provided health care services. Physicians were the first group to successfully obtain such state sanctioned control. Thus, the subsequent development of regulatory regimes of health care providers has been based upon, and done in the shadow of, a regulatory model designed to regulate medicine and grounded in a broad legal definition of medicine's scope of practice.[3]

The historical "why" of regulation, however, begs further questions of a more reflective nature. For example, why is regulation necessary at all? A question which at first might seem rather obvious, so much so that it does not require an answer. Nevertheless, it is a question which, in many cases, carries answers which are loaded with assumptions, some explicit, others implicit which in turn merely beg further questions the answers to which are evidenced in the regulatory regimes and accompanying debates over those regimes.

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[2] The use of a comparative analysis in this paper is to provide a method which allows one to evaluate health profession regulation issues, regulatory institutions and regulatory regimes from a broad perspective. Through such comparative methodology it becomes possible to make observations and gain perspective not possible in a mono-centric study. For a general discussion of comparative methodology and its relationship to legal structures and systems, see: K. Zweigert & H. K tz, *An Introduction to Comparative Law*, 3rd Edition rev., Transl. by T. Weir, (Oxford: Oxford University Press, 1998).

[3] For a discussion of medicine's ascendance within a social, political, economic and cultural context, see generally, Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, 1984); see also, B. Rose, *Professional Regulation: The Current Controversy*, 7 Law and Human Behavior 103 (1983); and W. Gellhorn, *The Abuse of Occupational Licensing*, 44 U. Chi. L. Rev. 6 (1976).

Generally speaking, as a general proposition one might posit that the regulation of human activity seeks to provide for at least three basic goods: (1) modes and orders; (2); definition to the activity being pursued; and (3) accountability. First, regulation provides for modes and orders (*i.e.*, authority, restrictions and bureaucratic structure) which allow for governance of the activity regulated. Second, regulation provides for definition of the activity (profession) through articulating a scope of practice for the activity, as well as the establishment of enforceable ethics and standards of practice. Third, regulation provides for accountability insofar as it establishes mechanisms (*i.e.*, complaints and discipline procedures) to hold those regulated accountable for their activities. Thus, regulation *qua* regulation aims at the orderly pursuit of a specifically defined activity in an accountable manner.

In the context of health professions, regulation allows various regulators to establish the necessary modes and orders, definition and accountability in which to regulate the providers of health care services and the services they provide.

At a deeper level, however, the general proposition of regulation of health professions does not fully address the question of "why regulation" due to the fact that health professions and health care providers are regulated in one way or another through state agency. In other words, legislation has been passed which enables professional regulation. Thus, the use of state action requires a further dimension of the "why" of regulation to be acknowledged, and that dimension is "public interest."

There exists a broad consensus among numerous jurisdictions that regulation of health professions is a matter of the public interest and not a profession's interest. In Ontario, the policy foundation to the *Regulated Health Professions Act*[4] regime produced by the Health Professions Legislation Review,[5] clearly articulated that the regulation of health professions must be done in the public interest:

> The important principle underlying each of the criteria [for regulation] is that the sole purpose of professional regulation is to advance and protect the public interest. The public is the intended beneficiary of regulation, not the members of the profession. Thus the purpose of granting self-regulation to a profession in not to enhance its status or to increase the earning power of its members by giving the profession a monopoly over the delivery of particular health services. Indeed, although these are common results of traditional regulatory models, they are undesirable results, and the model of regulation we recommend [the *RHPA*] aims to minimize them.[6]

[4] S.O. 1991, c.18, as am. Hereinafter referred to as *RHPA*.
[5] *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions* (Toronto: Queen's Printer, 1998). Hereinafter referred to as "HPLR".
[6] *Ibid.*, at p.9 – 10.

The public interest justification for professional regulation has been expressly adopted in legislation in a number of jurisdictions, for example: British Columbia,[7] Alberta,[8] Colorado,[9] Nebraska,[10] Florida,[11] Minnesota[12] and Virginia.[13] It should be noted that even where the legislation does not expressly refer to public interest, the very fact of legislation implies a public interest rationale to its enactment and objectives.[14]

In Ontario, the public interest *ratio* is further acknowledged in the *RHPA* regime by virtue of s. 3 of the *RHPA* which imposes a duty on the Minister of Health and Long-Term Care to, *inter alia* "ensure that the health professions are regulated and co-ordinated in the public interest . . ." In addition, s. 3(2) of the *Health Professions Procedure Code*[15] expressly states that the regulatory Colleges, in carrying out their corporate objects have a "duty to serve and protect the public interest." One finds similar legislative sentiments in other jurisdictions as well, for example: British Columbia,[16] Alberta,[17] England,[18] Hawaii,[19] Vermont,[20] and Colorado.[21]

While it is clear that there is a general consensus that health professions are regulated as a matter of public interest, with a clear objective of serving the public interest, there is no clear consensus that the public interest mandate is being fulfilled. For example, criticism is made of: (1) the continuing "turf" battles that are waged between various professions; (2) the monopolistic implications and impact of regulation, including the creation of artificial barriers to entry to practice, reduced competition, and restricted access to services; (3) lack of co-ordination between health professions; (4) regulatory regimes that are unable to adapt to changing technological/scientific innovations and advancements which in turn impact upon the efficient and effective delivery of health care services; (5) economic/political self-interest of the professions and regulators which are supported and encouraged though regulation; and (6) insufficient integration and/or co-ordination with other public and private consumer protection processes such as criminal or civil

[7] Sections 10(1) and 10(2), *Health Professions Act*, R.S.B.C. 1996, Chapter 183. Hereinafter referred to as *BCHPA*.
[8] Section 26(1) *Health Professions Act*, R.S.A. 2000, c.-H.7. Hereinafter referred to as *AHPA*.
[9] 24-34-104.1, General Assembly Sunrise Review of New Regulation of occupations and Professions.
[10] *Regulation of Health Professions Act*, R.R.S.Neb. Chapter 71, Art. 62, s. 6220.01.
[11] Title III, Legislative Review of Proposed Regulation of Unregulated Functions, Art. 11.62
[12] Chapter 214, *Examining and Licensing Board*, Minn. Stat. § 214.001.
[13] Title 54.1 Subtitle 1, Chapter 1, Sec. 54.1-100-54.1-311.
[14] General principles of statutory interpretation acknowledge that public laws must be construed in such a manner that furthers the public interest. See generally, Driedger, *Construction of Statutes*, 2nd ed. (Butterworths: Toronto, 1983).
[15] Schedule 2, of the *RHPA*. Hereinafter referred to as "*HPPC*".
[16] Section 16, *BCHPA*, *supra*, note 7.
[17] Section 3(1)(a), *AHPA*, *supra*, note 8.
[18] In England, recent reforms to General Medical Council, the body charged with the regulation of physicians, has placed protection, promotion and maintenance of the health and safety of the public as the main objective of the regulatory body: s.1, *Medical Act, 1983*, c. 54, as am.
[19] Hawaii Code Annotated 26H-2(1);
[20] Vermont Code, Title 26, Secs. 3101 and 3105.
[21] Colorado, 24-34-104.1(1).

remedies.[22] Such criticism has also received judicial notice. In *Illinois Psych. Ass.* v. *Falk,*[23] a case dealing with an Illinois administrative regulation which barred psychologists from membership on hospital medical staffs,[24] Posner J. commented:

> . . . there is now a large body of scholarly literature which questions the wisdom of occupational licensure and might question the wisdom of Illinois' excluding psychologists from hospital medical staffs. The scholars have found that governmental restrictions on the professions create barriers to entry, reduce competition, and raise professional incomes, without bringing about compensating increases in the quality of professional services.[25]

Nevertheless, Posner, J. notes that such literature "has yet persuaded the courts to reconsider their hands-off policy toward economic regulation challenged under the Constitution."[26]

In addition to the continuing debate about whether the public interest is really being served, there also exists the more fundamental question of what constitutes "public interest." In other words, of what does public interest consist?

In Ontario, "public interest" was addressed by the HPLR in the following terms:

> The Review's recommendations are aimed at advancing the public interest in four ways:
> - Protecting the public, to the extent possible, from unqualified, incompetent and unfit health care providers.
> - Developing mechanisms to encourage the provision of high quality care.

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[22] See generally, HPRAC, *Adjusting the Balance: A Review of the Regulated Health Professions Act*, (Toronto: The Queen's Printer, 2001); Milton Friedmen, *Capitalism and Freedom*, (Chicago: University of Chicago Press, 1962), pp. 139 – 160; Hogan, *The Effectiveness of Licensing: History, Evidence and Recommendations*, 7 Law and Human Behavior 117 (1983); B. Safriet, "Closing the Gap Between Can and May in Health-Care Providers: A Primer for Policy Makers" *19 Yale J. on Reg.* 301 (2002); Sue Blevins, *The Medical Monopoly: Protecting Consumers of Limiting Competition?* (CATO Institute, Policy Analysis No. 246, December 15, 1995); S. J. Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (Quorum Books: Westport, CT., 1994); and Taskforce on Health Care Workforce Regulation, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, (Pew Health Professions Commission: San Francisco, C.A., 1998) at p. 2.

[23] 818 F.2d 1337 (7th Cir. 1987).

[24] Without membership on hospital staffs, psychologists would have no admitting or treatment privileges, nor would they be able to vote on hospital policies. Accordingly, in order for a psychologist to be able to use a hospital facility, he or she would have to "work" with a psychiatrist, as the latter would be the only one who could admit or order treatment in the hospital.

[25] *Supra*, note 23 at 1341. Posner, J. cites the following in support of his *obiter*: Paul, *Physician Licensure Legislation and the Quality of Medical Care*, 12 Atl. Econ. J. 18 (1984); Leffler, *Physician Licensure: Competition and Monopoly in American Medicine, 21 J. Law & Econ. 165 (1978);* Gellhorn, *The Abuse of Occupational Licensing, 44 U. Chi. L. Rev. 6 (1976);* Maurizi, *Occupational Licensing and the Public Interest*, 82 J. Pol. Econ. 399 (1974); Shepard, *Licensing Restrictions and the Cost of Dental Care, 21 J. Law & Econ. 187 (1978);* Occupational Licensure and Regulation (Rottenberg ed. 1980); and Jordan, *Producer Protection, Prior Market Structure and the Effects of Government Regulation*, *15 J. Law & Econ. 151 (1972).*

[26] *Ibid.*

> - Permitting the public to exercise freedom of choice of health care provider within a range of safe options.
> - Promoting evolution in the roles played by individual professions and flexibility in how individual professions can be utilized, so that health services are delivered with maximum efficiency.[27]

In addition to the HPLR, one can also understand "public interest" in terms of the legislative regime enacted by the Ontario legislature. In other words, "public interest" can be understood and deduced from the legislation read as a whole, as the *RHPA* does not expressly define "public interest" as a specific term. Accordingly, one can see from the *RHPA* itself six public interest principles: Protection from Harm; Quality of Care; Accountability; Accessibility; Equity; and Equality.[28] Considering the HPLR's definition of "public interest" together with the *RHPA* read as a whole, it is not unreasonable to conclude that the chief public interest being served by the *RHPA* regime is to protect the public from harm and that other public interest principles fall within, and must be understood within the context of, the guiding principle of protection from harm.

In the American context, "public interest" is similarly understood in broad terms. It has been recognized that the "circumstances which clothe a particular kind of business with a 'public interest' as to be subject to regulation, must be such as to create a peculiarly close relation between the public and those engaged in it and raise implications of an affirmative obligation on their part to be reasonable in dealing with the public."[29] With respect to health care professions, "public interest" is understood in terms of "health, safety and welfare" and thus present a more explicit understanding of "public interest." Moreover, legislatures also have the ability to further define the content of that "health, safety and welfare." For example, Nebraska defines "welfare" to include "the ability of the public to achieve access to high quality health care at reasonable costs."[30]

A similar understanding of "public interest" to that of the HPLR has been offered by the Pew Health Professions Commission's Taskforce on Health Care Workforce Regulation.[31] The 1995 Taskforce articulated a set of five principles for the regulation of health care professionals that would, in its view, best serve the public interest:

- Promoting effective health outcomes and protecting the public from harm;
- Holding regulatory bodies accountable to the public;
- Respecting consumers' rights to choose their health care provider from a range of safe options;

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[27] HPLR, *supra*, note 5 at p. 2.
[28] These principles have been recognized and expounded upon by HPRAC in numerous Advice Memoranda, as well as being articulated in the Advisory Council's Request for a Change in Scope of Practice document, discussed *infra*.
[29] *Chas. Wolff Packing Co.* v. *Court of Industrial Relations of State of Kansas*, 262 U.S. 522, 43 St. Ct. 630 at 633.
[30] *Regulation of Health Professions Act*, R.R.S.Neb. Chapter 71, Art. 62, s. 6220.01.
[31] *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, Report of the Taskforce on Health Care Workforce Regulation (San Francisco, C.A.: Pew Health Professions Commission, 1995). Hereinafter referred to as "1995 Taskforce".

- Encouraging a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers; and
- Facilitating professional and geographic mobility of competent providers.[32]

Whatever conclusions may be drawn surrounding "public interest," it appears that it remains a flexible, fluid, debatable, yet central concept. While there exists a variety of answers to how best to protect the "public interest" there is a realization that health profession regulation must at least be justified in public interest terms, which ultimately suggest the political nature of the question and the resulting problems and solutions.

**When should regulation occur?**

The question of "when to regulate" is related to the "why" of regulation. If the answer to "why regulate?" is centred upon public interest, then the "when" to regulate is centred upon public interest criteria. In other words, when does the public interest require that any given health care profession be regulated?

As indicated above, the risk of harm or concern for the public's health, safety and welfare are the main rational underlying the "why" of regulation in terms of protecting the public interest. When should regulation occur is very much a matter of criteria recognition and fulfillment. In other words, regulation occurs when certain criteria have been meet. Thus, the criteria for regulation play an important part in specifically defining the public interest. A discussion of those criteria will be undertaken in Part II.

**What is Being Regulated?**

It is trite to observe that what is being regulated by regulations governing health care providers is the profession and hence the providers. In reality, regulation affects more than just a profession or its individual members. For example, regulation also affects – in varying degrees, treatment modalities, health care institutions such as hospitals, clinics, nursing homes, *etc*., Insurance providers, the health care services marketplace, other health care providers, consumers and the public.[33]

A profession will be primarily regulated through its scope of practice, title protection and licensure requirements. Treatment modalities are primarily regulated through standards of practice and by their use being restricted to those who belong to a particular profession. Health care institutions, such as hospitals, clinics, nursing homes *etc*., are impacted by health profession regulation in terms of staffing requirements, standards of care, and labour relations issues. Insurance providers are impacted through economic

[32] *Ibid*, at *vii*.
[33] It is this cacophonous cat's cradle of interdependence that animates much of the current attempts at regulatory reform as evidenced by such examples as: in the United States, the Pew Health Professions Commission's Taskforce on Health Care Workforce Regulation's policy documents and recommendations; and in Canada, the Romanow and Kirby Reports, respectively.

considerations *vis-à-vis* costs associated with the delivery of services. The health care services marketplace is itself regulated through the number of actors recognized and sanctioned to participate by virtue of their being regulated and who are therefore available to work in institutions or to act on behalf of insurance providers. In addition, the very cost of regulation *qua* regulation will effect the economies of scale and efficiency of the health care marketplace. Finally, consumers and the public are also impacted by regulation to the extent that their choices about, and access to, safe and effective health care requires that those providers be regulated. Moreover, the manner of the regulation will also impact those who are regulated as well as consumers and the public as they attempt to access regulatory mechanisms associated with maintaining the integrity of the regulatory system, *i.e.*, complaints and discipline processes and quality of care/patient relations programmes.

In addition, the "what" of regulation also cuts across all jurisdictions and can have an impact as between jurisdictions. For example, regulation that restricts or otherwise limits the number of health care providers in one jurisdiction may result in consumers in that jurisdiction looking to another jurisdiction for care. By going to another jurisdiction for care, they will also impact upon that jurisdiction to the extent that they are users of that jurisdiction's resources. A common illustration of this is found in Ontario where cancer patients seek treatment in New York or Michigan.

## II. PROCESS/PROCEDURE

The following process/procedure discussion will attempt to answer two basic questions of: who; and how.

### Who does the regulation?

The use of the term "regulation" itself denotes the existence of a "regulator." At a macro level, the regulator might be understood in terms of either state action (legislation) or the discipline of the free-market (*caveat emptor*). In either case, however, both are regulated by the state – the former by the state's involvement in the actual regulation of a profession, while in the latter by the state's regulation of the market through such means as criminal laws, consumer protection laws, security laws, and recourse to civil actions such as tort. In other words, to speak of regulation one is by definition concerned with the author of such regulation, the state.[34]

While the State may be the ultimate regulator, the responsibility for the regulation of health professions is a shared responsibility between state, profession, institutional and public actors. In Canada, the legal authority for provinces to be the primary regulator of health care professions is derived from s. 92(13) (Property and Civil Rights) of the

[34] This is not to suggest however, that the state is a Leviathan, regulating at will. The Regulator is itself regulated by important regulatory instruments and structures such as a Constitution – either written or unwritten, laws, the common law and hence the courts, and political/social convention.

*Constitution Act, 1867*.[35] In the United States, State authority to regulate health professions is derived from the Tenth Amendment of the United States Constitution and is an exercise of the state's police power.[36] In the United Kingdom, state regulatory authority resides with the Parliament at Westminster. In both Canada and the United States, where the power to regulate is derived from a federal constitution, any attempts to legislate a national regulatory regime would entail serious and profound consequences involving the nature of federalism as well as the very nature of the polities themselves.[37]

At a micro level, in every jurisdiction considered, the main regulator is the legislature who delegates its rule-making authority to regulate to various regulatory bodies. These bodies may be state departments, agencies, boards or professional bodies. In Canada and the United Kingdom, the common legislative means is for the legislature to delegate authority to the professions themselves through the use of regulatory Colleges[38] or Councils.[39]

In the United States, the mechanisms chosen are quite varied and range from state agencies – under the direct control of the executive, to boards and associations. A more detailed discussion of how regulation is achieved will be posited below.

At present, the point to be made with respect to "who does regulation" is that although authority may be delegated, the ultimate regulator remains the legislature. This ultimate control may not only be exercised by legislative fiat, but also through executive oversight. For example, s. 5(1) of the *RHPA* vests the Minister of Health and Long Term-Care with the power to require that a regulatory College:

> (a) inquire into or require a Council to inquire into the state of practice of a health profession in a locality or institution;
>
> (b) review a Council's activities and require the Council to provide reports and information;
>
> (c) require a Council to make, amend or revoke a regulation under a health profession Act or the *Drug and Pharmacies Regulation Act*;
>
> (d) require a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health profession Acts or the *Drug and Pharmacies Regulation Act*.

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[35] 30 & 31 Victoria, c. 3. See generally, *Re Imrie and Institute of Chartered Accounts of Ontario* [1972] 3 O.R. 275 (Ont. H.C.); *R.* v. *Buzunis* [1974] 4 W.W.W. 337 (Man. C.A.).

[36] The Tenth Amendment reads: The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the people.

[37] An example of this constitutional reality in the Canadian context was recently witnessed by reaction to the Commission on the Future of Health Care in Canada's Final Report, *Building on Values: The Future of Health Care in Canada* (Romanow Report) as well as the Senate's Standing Senate Committee on Social Affairs, Science and Technology's continuing Report, *Study on the State of the Health Care System in Canada*, (Kirby Report).

[38] Ontario's *RHPA* regime is an example of such delegation.

[39] In the United Kingdom, the licensing bodies are called Councils. Thus, medicine is regulated through the General Medical Council, dentists through the General Dental Council, nurses and midwives through the Nursing and Midwifery Council. Other professions, ranging from Art Therapists to Paramedics, are regulated through the Health Professions Council.

> (2) If the Minister requires a Council to do anything under subsection (1), the Council shall, within the time and in the manner specified by the Minister, comply with the requirement and submit a report.

Thus, while "self-regulation" is an important aspect of the *RHPA* specifically, and regulation of professions generally, there still remains the acknowledgement of the legislature's and executive's ultimate authority. Such acknowledgement reflects the fact that public interest is the definitive justification for state action, and thus the exercise of such authority remains very much a political rather than legal or clinical question.

**How is regulation achieved?**

As indicated above, legislatures delegate authority to any number of regulatory bodies. Thus, as a general proposition, one can imagine a continuum of regulatory models. At one end, the state directly regulates a health profession and at the other end, the profession is entirely self-regulating with minimal interference from the state. Within this continuum one finds a variety of models, with some being more free of the state's direct control than others. This continuum is best understood in terms of three constructs: (a) self-regulation; (b) modes; and (c) orders.

## A. Self-Regulation

Before addressing the modes and orders of regulation, it may first be propitious to consider what is meant by "self-regulation" of a profession. Depending upon the context, "self-regulation" can be understood in a number of different ways. For example, in the context of professional discipline or clinical review, self-regulation means that a member's professional conduct is judged by a jury of their peers. Indeed, for many professions, whether health or other, the true hallmark of self-regulation is peer review in clinical review and disciplinary proceedings.

In another context, an understanding of self-regulation may be primarily associated with the setting of standards, be they entry to practice, ethical, or the clinical Standards of Practice of the profession regardless of who is doing the disciplining.

Finally, the broadest conception of self-regulation is arguably found in governance. In other words, who *governs* the profession? If a majority of members govern the profession, then true self-regulation can be said to exist. From the governance structure flow the necessary requirements and means of achieving and maintaining professional membership and responsibility, including such requirements as entry to practice, standards of practice and peer review. As will become apparent in the following discussion, "self-regulation," like "public interest" is a flexible concept across jurisdictions and its understanding is best derived from the modes and orders which evidence it. Moreover, it should be acknowledged that much of "self-regulation" may better be described as "self-administration", particularly in cases where legislative and/or executive control is a significant reality.

## B. Modes of Regulation

Modes of regulation consist of various mechanisms whereby individuals are granted the privilege, and therefore the right, to perform certain activities. The privilege/right may be exclusive and restrictive or inclusive and general.

These mechanisms represent a continuum from complex to simple. Three main mechanisms of regulation are aptly characterized in the literature.[40] The first and most restrictive mode is "**Licensure**" which entails the creation of a profession monopoly on the activity regulated through the enactment of profession-specific *practice* Acts, "the licensed practitioners gain an exclusive right to deliver services."[41] In addition, the profession also enjoys title protection.[42]

The second mode, "**Certification**" - achieved through the use of *title protection* Acts, is less restrictive and involves the giving of designated "recognition to individuals who have met predetermined qualification set by a regulatory agency."[43] Non-certified individuals may still offer services, but they are prohibited from using the term "certified" or using the designated title. Certification may be used in licensure models, where such certification denotes that a licensed practitioner has meet certain professional standards.[44]

The third mode, "**Registration**" is the least restrictive and is achieved through *registration requirement* Acts. In essence, "registration requires an individual to file his or her name and address with a designated agency."[45] Unlike the licensure model, registration does not require complex or onerous pre-entry screening requirements, nor is a registration regime exclusionary. Thus, at best, it "does little more than provide a roster of practitioners."[46]

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[40] For example, see: *Questions A Legislator Should Ask* (The Council on Licensure, Enforcement and Regulation: Lexington, 1994) at pp.3 – 7, hereinafter referred to as "*Questions*"; and Lisa Bartra, *Reconsidering the Regulation of Health Professionals in Kansas*, 5 Kan. J. L. & Public Pol'y 155 (1996) at pp. 156 - 158.

[41] *Ibid*, *Questions*, at p. 3.

[42] An example of this type of regime would be the *RHPA*, as well as all legislation regulating health professions such as medicine, dentistry, *etc*. Even in Ontario where the "license" has been changed to a "certificate of registration" the Ontario *RHPA* regime is still based upon restriction and the creation of monopolies of practice, albeit now the monopolies are really polyopolies due to shared scopes of practice made possible by the Controlled Act/Authorized Act mechanism contained in s. 27 of the *RHPA*.

[43] *Questions*, *supra*, note 40 at p.6.

[44] For example, under the Kansas *Public Health Act*, *Physical Therapy Chapter* S.K.A. § 65 - 2913, those who have met specific standards may be certified as physical therapy assistants and may so describe themselves as such using protected titles of physical therapist assistant (P.T.A. or P.T. Asst.) or certified physical therapist assistant C.P.T.A. Similarly, in Ontario, the *RHPA* expressly provides College with the authority to create specialties in the profession with certification and restrictions on title relating to the use and terms of the specialty certification: *HPPC*, s. 95(1)(c).

[45] *Questions*, *supra*, note 40 at p. 4 - 5.

[46] *Ibid*, at p. 5. An example of such a regime is found in Kansas, were the Board of Healing Arts maintains a register of individual who are "physicians' assistants." In order to qualify for registration, one must meet certain pre-determined qualification such as proof of graduation from an approved education programme.

## C. Orders of Regulation

Orders of regulation consist of the institutions, structures – both bureaucratic and governance, and laws whereby a profession is actually regulated.

Regulation of health professions is achieved through any number of orders. When legislation is used to regulate a profession, the ultimate regulator is the legislature. How regulation is achieved, however, will reflect the choices made which allow the legislature to delegate its regulatory authority over a profession to another body. Thus, one can speak of a continuum of regulatory orders, with direct government control at one end and running through complete profession self-regulation at the other, with a variety of possible orders in between. The following are the three main orders.

**Direct State Control** – in this order, the state is responsible for all aspects of regulation and administration, from setting entry to practice requirements, to professional standards, investigating complaints, discipline *etc*. These functions can occur with or without the assistance of an advisory board comprised of the profession regulated under this order. This is the least used order for regulation.[47]

**Partial Self-Regulation** – in this order, the profession might be self-governing in the sense of governing membership or it might find itself being governed by a dominant related profession.[48] However, any number of functions will be undertaken by a state agency. Such functions could include: administrative support, investigation of complaints, adjudication of discipline matters. This is the order which a majority of American states utilize in some form or another[49] and is the order that best describes the United Kingdom's Health Profession Council.[50]

**Self-Regulation** – in this order, professions are self-governing, with at least 50% plus 1 of the governing entity being comprised of members of the profession either appointed by the state executive or elected from the membership. The governing entity – whether a Council, Board or College, is responsible for all decisions both administrative and profession-specific, *i.e.*, clinical, ethical, investigative and disciplinary. This is the predominate order reflected in Canada, the United Kingdom amongst traditional professions such as medicine, nursing and dentistry, and a number of American jurisdictions.[51]

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A non-state example can be found in the American Medical Association's scheme of specialty boards which certify physicians specializing in different practice areas.

[47] For example, New York State, where the majority of health care professions are licensed and regulated by the Board of Regents (a citizen body) and the Office of the Professions of the Department of Education, and a few by the Department of Health.

[48] For example, in Ontario under the old *Health Disciplines Act*, R.S.O. 1990, c. H- , dental hygienists were regulated by the Royal College of Dentists.

[49] For example, Alaska, Connecticut, Florida, Hawaii, California and Montana.

[50] Discussed in greater detail, *infra*.

[51] For example, Alabama, Iowa, New Hampshire and South Dakota.

## SUMMARY - PART I

Consideration of the regulatory themes associated with models of regulation have provided the following answers to the basic questions:

Why regulation? Despite being a flexible and debated concept, public interest is the only justification for regulation. What content is given to "public interest" varies among jurisdictions, however, protection from harm and the advancement of the public's health, safety and welfare are paramount considerations. The determination of those considerations remains a political judgment.

When should regulation occur? When criteria – which are specific aspects of the public interest, have been met that address the public's safety, health and welfare.

What is being regulated? Not only health professions, but a number of other actors and institutions are also impacted by the regulation of a given profession.

Who does the regulation? The legislature is the primary regulator, but that authority has been delegated to others, including state agencies, board and the professions themselves.

How is regulation achieved? Regulation is achieved through various modes and orders, which are not necessary mutually exclusive, the choice of which will depend upon the legal, professional, economic, and social cultures in which they are employed.

## PART II – REGULATION/DE-REGULATION OF HEALTH PROFESSIONS

The Second Part of this paper will consider the substantive policy and process/procedure issues associated with requests for Regulation/De-regulation.

### REQUESTS FOR REGULATION

### I. SUBSTANTIVE POLICY

#### Why is a request made?

As discussed in Part I, the question of why regulation occurs is centered upon an examination of the public interest.

During the HPLR, over 75 professions sought regulation, however, the number accepted at that time was 23. Nevertheless, health care professions are in a constant state of flux, as new professions emerge due to changes in technology, economics, politics, science and our intellectual understanding of what constitutes "health care."

As health care evolves and the range of duties and responsibilities taken on by health care providers change, the potential for risk of harm from the performance of a particular profession often increases. Moreover, changes in educational programs, accreditation standards, the introduction of new technologies and the development of new treatment modalities often allow unregulated health care providers the opportunity to learn new skills and take on additional responsibilities. With this additional responsibility, there is the potential for increased risk of harm to the public. As a result, the question of regulation is raised as a means to mitigate this risk and as a matter of public interest.

In addition to public interest, professions - in their own interest and the interest of their members, may be motivated to seek regulation for any number of reasons. For example: in order to obtain a legal power to establish and enforce standards of practice or accreditation standards; to promote and protect economic advantage through restrictions of competition; to acquire the ability to become entitled to receive third-party payments (*e.g.*, from government or insurance companies); and for professional prestige.

#### When is a request made?

When a request is made is very much a matter that depends upon the requester as well as the evolving political, social, economic and/or professional context in which, and from which, the request is made. Given the existence of known criteria which various regulators have adopted, anyone making a request for regulation would at least have to be fairly certain that they had a strong possibility of meeting the criteria.[52]

[52] This is particularly true in jurisdictions such as Alberta and British Columbia which levy an application fee and therefore the process of reviewing a request can become financially significant for a profession which faces the additional costs of a lengthy investigative review process. For example, in British Columbia the application fee is $2,000.00. In addition, the Minister can also charge an association

If the question of "why regulate" is centred upon the public interest, then the question of "when to regulate" is centred upon an analysis of the public interest criteria that would justify regulation. As discussed in Part I, "public interest" is a flexible, fluid, debatable, yet central concept. It should come as no surprise therefore that the criteria used to assess a request for regulation is not without debate. Nevertheless, the existence of criteria attempts to provide some objective standards against which to measure the public interest. In other words, criteria allows for the assessment of a request in terms of objective and verifiable (evidence-based) standards without recourse to political argument. A criteria-based request process allows for a pro-active, open and accountable assessment of the regulatory request to ensure that it is the public interest that is being served rather than the interests of those who seek regulation or the interests of those who grant regulation.

## Ontario

Requests for regulation can be made when the Minister of Health and Long-Term Care deems it necessary, *e.g.*, the Minister becomes aware of a potential risk of harm to the public, or as a result of health human resources planning exercises. Alternatively, requests can be made by professional organizations seeking legitimacy or a means to protect the public through the establishment and enforcement of entry to practice requirements, standards of practice, complaints and discipline processes, etc. Although the public at times expresses its support for particular requests for regulation, rarely, if ever, do members of the public initiate these requests.[53]

With respect to requests for regulation, HPRAC developed a policy document in 1994 which outlined the process and the criteria to be used by the Advisory Council in providing its advice to the Minister of Health and Long-Term Care regarding new professions requesting regulation under the *RHPA*. This document was revised in 1999. The nine criteria outlined within the initial policy document, and its revision, were based on those developed by the HPLR during its deliberations.[54] For ease of reference, a copy of HPRAC's Request for Regulation policy document is attached at Appendix D. The nine criteria are:

> **Criterion #1: Relevance to the Minister of Health**
>
> A substantial portion of the profession's members are engaged in activities that are under the jurisdiction of the Minister of Health and the primary objective of the treatments/services they provide is the promotion or restoration of health.

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additional costs after the first $7,500.00 of investigation costs associated with the association's application for regulation: see, *BCHPA* , s. 9(5); and ss. 2 and 3 of *Health Profession Regulation*, B.C. Reg. 237/92, as am.

[53] Kara Schmitt & Benjamin Shimberg, *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, (CLEAR: Lexington, KT, 1996) at p. 13, hereinafter referred to as "*Demystifying*", confirms that the American experience is the same as Ontario.

[54] The HPLR developed four criteria issues to consider the question of regulation based on deliberations with relevant stakeholders during the HPLR review process. In its 1989 report, the HPLR indicated that the criteria for regulation were adopted and universally endorsed by stakeholders.

**Criterion #2: Risk of Harm**

A substantial risk of physical, emotional or mental harm to individual patients/ clients arises in the practice of the profession

**Criterion #3: Sufficiency of Supervision**

A significant number of members of this professions do not have the quality of their performance monitored effectively, either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professions who assign this professions' services

**Criterion #4: Alternative Regulatory Mechanism**

The profession is not already regulated effectively or will not soon be regulated effectively under some other regulatory mechanism.

**Criterion #5: Body of Knowledge**

The members of this profession must call upon a distinctive, systematic body of knowledge in assessing, treating or serving their patients/clients. The core activities performed by the members of this profession must be discernible as a clear and integrated whole and must be broadly accepted as such within the profession.

**Criterion #6: Educational Requirements for Entry to Practice**

To enter the practice of the profession, the practitioner must successfully complete a post-secondary program offered by a recognized educational institution. The educational program must be available in Canada. Governing bodies may register individuals from other jurisdictions with equivalent training, in compliance with the entry to practice regulation.

**Criterion #7: Leadership's Ability to Favour the Public Interest**

The profession's leadership has shown that it will distinguish between the public interest and the profession's self-interest and in self-regulating will favour the former over the latter.

**Criterion #8: Likelihood of Compliance**

The members of this profession support self-regulation for themselves with sufficient numbers and commitment that widespread compliance is likely.

**Criterion #9: Sufficiency of Membership Size and Willingness to Contribute**

The practitioners of the profession are sufficiently numerous to staff all committees of a governing body with committed members and are willing to accept the full costs of regulation. At the same time, the profession must be able to maintain a separate professional association.

## Alberta

Unlike Ontario where the *RHPA* does not contain any statutory criteria to be considered, the *AHPA* clearly articulates 10 minimum factors to be considered by HPAB when making its recommendations to the Minister. They are:

(a) evaluate the risk to the physical and psychological health and safety of the public from incompetent, unethical or impaired practice of the profession;

(b) ascertain what constitutes the practice of the profession, whether persons practising the profession should be authorized to provide restricted activities and the conditions, if any, that should apply to the practice of the profession or the provision of restricted activities;

(c) evaluate and make recommendations on the services normally provided by a person practising the profession, including the complexity of the services and how they are carried out;

(d) consider whether the services normally provided by persons practising the profession are regulated by an enactment;

(e) consider whether the profession is a distinct and identifiable profession;

(f) consider whether the proposed protected title is appropriately descriptive and whether it is likely to cause public confusion;

(g) consider the potential costs and benefits of regulating the profession, including the expected effect on practitioner availability and on education and training programs, the expected effect on enhancement of quality of service and the expected effect on prices, access and service efficiency;

(h) ascertain the qualifications and minimum standards of competence that are required for a person applying to practise the profession and how the continuing competence of practitioners is to be maintained, ascertain what education programs are available and evaluate the available education programs;

(i) ascertain the ability of the proposed college of the profession to carry out its powers and duties under this Act or consider whether they could be carried out by an existing college;

(j) evaluate the effect, if any, that there would be on any agreements on trade and mobility to which Canada or Alberta is a signatory if the profession would become a regulated profession;

(k) on the request of the Minister, consider any other matter.[55]

The criteria are similar to those developed by the HPLR in Ontario and used by HPRAC. However, it is worth noting three significant criteria, absent in Ontario, that the *AHPA* specifically requires HPAB to consider: (1) the potential costs and benefits of regulating the profession, including the "expected effect on practitioner availability and on education and training programs, the expected effect on enhancement of quality of service and the expected effect on prices, access and service efficiency";[56] (2) the requirement to review the potential effects (of regulation) on any agreements on trade and mobility; [57] and (3) the evaluation of "available education programs" which provide the "qualifications and minimum standards of competence . . . and continuing competence" to practice the profession.[58]

[55] *AHPA*, s. 25(4).
[56] *AHPA*, s. 25(4)(g).
[57] *AHPA*, s. 25(4)(j).
[58] *AHPA*, s. 25(4)(h).

**British Columbia**

Regulations made pursuant to the *BCHPA* outline four mandatory criteria relating to harm, and 8 optional criteria relating to other aspects of regulation, to be considered by the Health Professions Council when making recommendations on whether a health profession should be designated under the *BCHPA*. The Regulation providers as follows:

> **5** (1) For the purposes of section 10 (1) of the Act, the council must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well being of the public, having regard to
>
> (a) the services performed by practitioners of the health profession,
>
> (b) the technology, including instruments and materials, used by practitioners,
>
> (c) the invasiveness of the procedure or mode of treatment used by practitioners, and
>
> (d) the degree to which the health profession is
>
> > (i) practised under the supervision of another person who is qualified to practise as a member of a different health profession, or
> >
> > (ii) practised in a currently regulated environment.
>
> (2) The council may also consider the following criteria:
>
> (a) the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession;
>
> (b) the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well being of the public;
>
> (c) the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession;
>
> (d) whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution;
>
> (e) whether it is important that continuing competence of the practitioner be monitored;
>
> (f) the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest;
>
> (g) the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the council may affect the viable operation of the college;
>
> (h) whether designation of the health profession is likely to limit the availability of services contrary to the public interest.[59]

The criteria are consistent with those identified in Ontario. However, it should be noted that the British Columbia criteria expressly place the assessment of risk of harm as a priority. In addition, it should also be noted that there may be consideration of evidence

[59] *Health Professions Regulation*, B.C. Reg. 237/92, as am.

of a "demonstrate benefit" to the public's health, safety and well being.[60] Evidence to substantiate regulation is similar to the Alberta regime that requires a consideration of "potential costs and benefits of regulating the profession."[61] Clearly, both the Alberta and British Columbia regimes contemplate, in addition to harm, a cost/benefits analysis to regulation requests which seems to beg a consideration of the efficacy of the profession's treatment modalities.

**Quebec**

The criteria for regulation of a health profession are included in the *Code des professions* or *Professional Code,*[62] which provides as follows:

> 25. To determine if a professional order should or should not be constituted or if a group of persons should or should not be integrated into one of the orders referred to in Division III of Chapter IV, account shall be taken particularly of the following factors:
>
> 1) the knowledge required to engage in the activities of the persons who would be governed by the order which it is proposed to constitute;
>
> 2) the degree of independence enjoyed by the persons who would be members of the order in engaging in the activities concerned, and the difficulty which persons not having the same training and qualifications would have in assessing those activities;
>
> 3) the personal nature of the relationships between such persons and those having recourse to their services, by reason of the special trust which the latter must place in them, particularly because such persons provide them with care or administer their property;
>
> 4) the gravity of the prejudice which might be sustained by those who have recourse to the services of such persons because their competence or integrity was not supervised by the order;
>
> 5) the confidential nature of the information which such persons are called upon to have in practising their profession. 1973, c. 43, s. 25; 1994, c. 40, s. 20; 1998, c. 14, s. 3; 1999, c. 40, s. 58.

**United States**

The Council on Licensure, Enforcement and Regulation ("CLEAR") reports that at least 14 states have passed "sunrise" legislation provisions to consider the regulation of new professions – as well as to assess changes in scope of practice of currently regulated professions. Within this process, members of the professions must propose the

[60] *Ibid*., s.5(2)(b).
[61] *AHPA*, s. 25(4)(g).
[62] R.S.Q. C-26.

components of the legislation and provide cost and benefit estimates for the proposed regulation.[63] Minnesota and Virginia will serve as examples.

**Minnesota**

As in Alberta and British Columbia, a number of American statutes include specific criteria that must be met for regulation to be considered. For example, in Minnesota, the *Examination and Licensing Board Act*[64] specifies that "no regulation shall be imposed upon any occupation unless required for the public health, safety or well-being." [65] The state puts the onus on the proponents of regulation to make a case for regulation. The Minnesota law lays out four criteria for regulation:

1. whether the unregulated practice of an occupation may harm or endanger the health, safety, and welfare of citizens, and whether the potential for harm is recognizable and not remote;

2. whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;

3. whether citizens are or may be effectively protected by other means; and

4. whether the overall cost effectiveness and economic impact would be positive.[66]

These criteria also apply to any increase in regulation (*i.e.*, change in scope of practice), that may be contemplated by a particular profession.

In addition to these criteria, there must also be evidence in support of regulation which considers the following:

> (1) the harm to the public that is or could be posed by the unregulated practice of the occupation or by continued practice at its current degree of regulation;
>
> (2) any reason why existing civil or criminal laws or procedures are inadequate to prevent or remedy any harm to the public;
>
> (3) why the proposed level of regulation is being proposed and why, if there is a lesser degree of regulation, it was not selected;
>
> (4) any associations, organizations, or other groups representing the occupation seeking regulation and the approximate number of members in each in Minnesota;

[63] *Sunrise, Sunset and Agency Audits*, (Council on Licensure, Enforcement and Regulation: Lexington, Kentucky, 2001) at www.clearhq.org/sunset/htm.
[64] Minn. Stat. Chapter 214.
[65] *Ibid*., § 214.001
[66] *Ibid*, § 214.002. These criteria are based on the Bateman criteria - a set of criteria developed by a New Jersey legislative commission in 1971 chaired by State Senator Ray Batemnen, *Regulating Professions and Occupations*, (A Report of the New Jersey Professional and Occupational Licensing Study Commission, 1971)

(5) the functions typically performed by members of this occupational group and whether they are identical or similar to those performed by another occupational group or groups;

(6) whether any specialized training, education, or experience is required to engage in the occupation and, if so, how current practitioners have acquired that training, education, or experience;

(7) whether the proposed regulation would change the way practitioners of the occupation acquire any necessary specialized training, education, or experience and, if so, why;

(8) whether any current practitioners of the occupation in Minnesota lack whatever specialized training, education, or experience might be required to engage in the occupation and, if so, how the proposed regulation would address that lack;

(9) whether new entrants into the occupation would be required to provide evidence of any necessary training, education, or experience, or to pass an examination, or both;

(10) whether current practitioners would be required to provide evidence of any necessary training, education, or experience, or to pass an examination, and, if not, why not; and

(11) the expected impact of the proposed regulation on the supply of practitioners of the occupation and on the cost of services or goods provided by the occupation.

(12) typical work settings and conditions for practitioners of the occupation; and

(13) whether practitioners of the occupation work without supervision or are supervised and monitored by a regulated institution or by regulated health professionals.[67]

## Virginia

The state of Virginia's Department of Health Professions adopted in 1991, and re-adopted in 1998, the following seven criteria:

**Criterion One: Risk for Harm to the Consumer**
The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

**Criterion Two: Specialized Skills and Training**
The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

**Criterion Three: Autonomous Practice**
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

[67] *Supra*, note 63, §214.002.

**Criterion Four: Scope of Practice**
The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

**Criterion Five: Economic Impact**
The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

**Criterion Six: Alternatives to Regulation** There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

**Criterion Seven: Least Restrictive Regulation**
When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.[68]

The seven criteria are similar to those in Ontario; they focus on risk of harm, specialized skills and training, autonomous practice and alternatives to regulation. The one exception is Criterion Five, which addresses the economic impact of the proposed regulation.

The Pew Health Professions Commission's Taskforce on Health Care Workforce Regulation's 1998 Report,[69] recommended that all states develop comprehensive sunrise and sunset processes to review proposals to change the practice authority of a profession or create a newly regulated profession. The Commission indicated that the process should establish criteria, provide for public participation and use evidence-based decision-making.[70] These criteria will be discussed more fully in Part III in the context of changes to scopes of practice.

Researchers at the Center for Health Professions at the University of California – San Francisco, have developed a model for evaluating emerging health professions that may prove informative for other jurisdictions. In *Profiling the Professions: A Model for Evaluating Emerging Health Professions*[71], the authors examine how emerging professions should come into traditional health care practice and what considerations consumers, private health care companies and public policy bodies should explore prior to supporting their inclusion into the mainstream. The Report argues that there are five issues to consider when developing a model of how a profession becomes recognized:

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[68] Virginia Board of Health Professions, *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*, (Virginia Board of Health Professions: Richmond, VA., 1998), at p. 5.
[69] *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, (Pew Health Professions Commission: San Francisco, 1998). Hereinafter referred to as "1998 Taskforce".
[70] *Ibid*., at p. 53 – 55.
[71] C. Dower, E. O'Neil and H. Hough, *Profiling the Professions: A Model for Evaluating Emerging Health Professions*, (Centre for Health Professions, University of California at San Francisco: San Francisco, CA., 2001).

- definition/description of the profession – this is important because all interested parties need sufficient information in order to understand what a profession does and how they do it[72]
- safety and efficacy – safety is of paramount importance to legislators and is very important to consumers; efficacy is less important to legislators but very important to consumers[73]
- government and private sector recognition – legislators, consumers and insurers need information regarding the profession's regulatory status in other jurisdictions[74]
- education and training[75]
- proactive practice model and viability of the profession[76]

**United Kingdom**

The Health Professions Council conducts a two-part assessment of applications for regulation. Part A is an evaluation of the profession's eligibility for regulation – which includes a review of the risk of harm associated with the practice of the profession. Part B is an assessment of the profession's ability to meet the 10 criteria for regulation. Those criteria are:

1. Cover a discrete area of activity displaying some homogeneity
2. Apply a defined body of knowledge
3. Practise based on evidence of efficacy
4. Have at least one established professional body which accounts for a significant proportion of that occupational group
5. Operate a voluntary register
6. Have defined routes of entry to the profession
7. Have independently assessed entry qualifications
8. Have standards in relation to conduct, performance and ethics
9. Have disciplinary procedures to enforce those standards
10. Be committed to continuous professional development[77]

[72] *Ibid*., at pp. 5 – 7.
[73] *Ibid*., at pp. 8 – 11. The authors argue that legislators are less interested in effectiveness of a particular profession, treatment or modality because "health professions regulation cannot be grounded in whether something works, only in whether it presents potential danger to the public." *Ibid*, at p. 9. This is necessarily so because regulation, as an exercise of the state's police power, must be justified in terms of public protection. However, it could be also be argued that "whether something works" is just as important as "risk of harm" for regulation review purposes. As will be noted from the United Kingdom example, one of the clear criteria to consider regulation is that the "practice [be] based on evidence of efficacy." See United Kingdom discussion, *infra*.
[74] *Ibid*., at pp. 12 – 15.
[75] *Ibid*., at pp. 16 – 19.
[76] *Ibid*, at pp 20 - 22.
[77] HPC, *Guidance for Occupations Considering Applying for Regulation by the Health Professions Council*, (HPC: London, 1993).

The HPC criteria are based on generally accepted principles of professional regulation and are similar to those applied in Ontario, Alberta, B.C., and American jurisdictions.

**What is being requested?**

Regulation under the *RHPA* in Ontario, as with most other jurisdictions, confers a certain legitimacy or sense of belonging to those professions who are deemed to have met the criteria for regulation. It is also an indication that the profession in question is ready to assume the duties and obligations of professional regulation, including the financial responsibilities and demonstrations of appropriate leadership to favor the public interest over that of the profession.

At a practical level, the answer to "what is being regulated?" depends upon the nature of the profession seeking regulation. For example, in the context of the *RHPA*, besides title protection, the applicant profession would also be seeking an exclusive Scope of Practice which might, or might not, contain authorized acts or even a new controlled act. In the American context, the "what" of the regulation request could relate to the mode of regulation granted, *i.e.*, registration, certification or licensure.

The nexus between the order of regulation and the criteria for regulation is aptly provided by the Virginia Department of Health Profession's *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*:[78]

> **Licensure.** Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.
>
> RISK: High potential, attributable to the nature of the practice.
> SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
> AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
> SCOPE OF PRACTICE: Definable in enforceable legal terms.
> COST: High
> APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.
>
> **Statutory Certification.** Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.
>
> RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.

[78] *Supra*, at note 68.

SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
SCOPE OF PRACTICE: Definable, but not stipulated in law.
COST: Variable, depending upon level of restriction of supply of practitioners.
APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

**Registration.** Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.
SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.
AUTONOMY: Variable.
APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.[79]

Similarly, Minnesota law also requires a nexus between criteria and mode of regulation. Section 214.003 of the *Examining and Licensing Board Act* provides:

> If the legislature finds after evaluation of the factors identified in subdivision 2 that it is necessary to regulate an occupation not heretofore credentialed or regulated, then regulation should be implemented consistent with the policy of this section, in modes in the following order:
>
> (a) Creation or extension of common law or statutory causes of civil action, and the creation or extension of criminal prohibitions;
>
> (b) Imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts;
>
> (c) Implementation of a system of registration whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications; or
>
> (d) Implementation of a system of licensing whereby a practitioner must receive recognition by the state of having met predetermined qualifications, and persons not so licensed are prohibited from practicing.
>
> Two or more of these modes may be simultaneously implemented if necessary and appropriate.

## II. PROCESS/PROCEDURE

### Who makes the request?

In Ontario, anyone can ask the Minister of Health and Long Term-Care to refer a matter to "the Advisory Council [of] any issue described in clauses 11 (1) (a) to (d) that a [College] Council or person requests the Minister to refer to the Advisory Council unless, in the Minister's opinion, the request is not made in good faith or is frivolous or

[79] *Ibid*. at p. 6. For ease of reference, the seven criteria cited, and noted earlier are: (1) Risk for Harm to the Consumer; (2) Specialized Skills and Training; (3) Autonomous Practice; (4) Scope of Practice; (5) Economic Impact; (6) Alternatives to Regulation; (7)Least Restrictive Regulation.

vexatious."[80] In the alternative, the Minister may, under s. 11(1) initiate a request, and ask for the Advisory Council's advice on whether a profession should be regulated.

As noted above, requests for regulation are invariably made by professional organizations representing, or purporting to represent, the majority of members in the profession. In some jurisdictions, the request is limited to either the executive, *i.e.* minister, or a profession who has a majority of the membership.[81] In other jurisdictions, there is no majority requirement.[82]

**How is the request made?**

**Ontario**

With the passing of the *RHPA*, the Health Professions Regulatory Advisory Council (HPRAC) was established as an arms-length advisory body to the Minister of Health and Long-Term Care on matters relating to the regulation of health professions.[83] Specifically, HPRAC has the mandate to provide advice to the Minister regarding:

- the regulation/de-regulation of health professions;
- amendments to the RHPA and profession-specific Acts, regulations under any of the Acts or suggested regulations under any Acts;
- matters concerning the quality assurance programs of the Colleges; and,
- any matter the Minister refers to the Advisory Council.[84]

An individual or organization may request regulation under the *RHPA* by writing to the Minister of Health and Long-Term Care and requesting a referral of the issue to the Advisory Council. Once the referral is made, HPRAC then determines the nature of process to be followed.[85] The Referral process seeks to gain input from a variety of sources including the public, interest groups, health professionals, health professional regulatory colleges and associations as well as from the professions seeking regulation. Depending upon the nature and scope of the referral, a variety of consultation methods are used including written submissions, public hearings, focus groups, and community meetings.

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[80] *RHPA*, Section 12.
[81] For example, Alberta, ss. 25(1) and (2) of the *AHPA*.
[82] In British Columbia, only health profession associations may apply, but they do not necessary need to represent a majority of the profession: *BCHPA*, s. 7(1). The same is also true in the United Kingdom.
[83] The Advisory Council is made up of up to seven members, appointed by the Lieutenant Governor in Council, on the Minister's recommendation. None of the members can belong to a regulated health profession a College Council or be a public servant. *e.g.* bureaucrat: *RHPA*, ss. 7 & 8.
[84] *RHPA*, s. 11(1). In addition to giving advise with respect to these items, HPRAC also has an independent statutory duty under s. 11(2)of the *RHPA*, to monitor each College's patient relations program and to advise the Minister about its effectiveness.
[85] Section 15(2) of the *RHPA* allows HPRAC complete discretion is determining the manner of its proceedings.

After extensive consultation and research, the Advisory Council provides its advice to the Minister of Health and Long-Term Care in the form of an advisory memorandum. As with all HPRAC Advise Memoranda, HPRAC's report with respect to the request for regulation remains confidential until the Minister releases it to the public.

Two other Canadian jurisdictions have followed the Ontario model respecting health profession regulation, Alberta and British Columbia .[86]

**Alberta**

In 1999, the Alberta Legislative Assembly passed the *Health Professions Act*[87] to regulate 30 self-governing health professions. The *AHPA* provided for the creation of the Health Professions Advisory Board ("HPAB"), an advisory body similar to HPRAC, to provide advice to the Alberta Minister of Health and Wellness.[88]

With regards to applications for regulation, professions seeking regulation under the *AHPA* must apply to the Minister of Health and Wellness. Applications must be from an organization that represents the majority of persons carrying out the profession in Alberta.[89] The Applicant must also pay an application fee as set by the Minister.[90] The Minister then may direct the Advisory Board to investigate whether the profession should be regulated. Such investigation is conducted as the Advisory Board "considers necessary."[91]

The Alberta Health Professions Advisory Board is a relatively new entity and has not yet had the opportunity to review a request for regulation.[92] A request for the regulation of Traditional Chinese Medicine will begin the review process in May 2003.[93]

[86] By 1999, the provinces of British Columbia and Alberta had modeled their systems of health professions' regulation after the system developed and implemented in Ontario. All other Canadian provinces, with the exception of Quebec , continue to regulate health professions using a licensing scheme whereby professions are granted a monopoly on providing their particular services to the public. In these provinces, decisions regarding the regulation of new health professions are made by the relevant government Ministry or Department. The parties are not bound by formal policies, criteria or processes that are written into legislation. The province of Quebec has developed a 'hybrid' system which is detailed later in this paper.
[87] *Supra,* note 8.
[88] The Minister may ask the board to provide advice on such things as applications to regulate new professions and proposals to expand a profession's scope of practice to include new restricted activities. The Advisory Board in Alberta is composed of 75% public members; the remaining 25% are regulated health professionals. (Alberta Health and Wellness, 2002)
[89] *AHPA*, ss. 25(1), 25(2)(a).
[90] *AHPA*, s. 25(2)(c).
[91] *AHPA*, s. 25(4).
[92] The Advisory Board was appointed in May 2002; its first meeting was held in July 2002.
[93] Email correspondence dated March 24, 2003, from Charlene Crowe, Health Professions Consultant, Alberta Health and Wellness.

**British Columbia**

In British Columbia, the legislature enacted a new regulatory regime in the early 1990s under the *Health Professions Act*.[94] Similar to Ontario and Alberta, it provides a common regulatory structure for the regulation of health professions, and a process for the consideration of requests for regulation. The *BCHPA* also established an advisory body, the Health Professions Council, to provide advice to the B.C. Minister of Health Planning on the regulation of health professions.[95] As will noted, although the Health Professions Council is now defunct, its processes will be discussed as relevant examples of process and procedure.

Contrary to Ontario and Alberta, requests for regulation of a new health profession in B.C. must be made directly to the Health Professions Council by the professional association seeking to be regulated.[96] The Health Professions Council can then decide to investigate the request, grant the request without investigation or dismiss the request.[97] Alternatively, the Minister may direct the council to investigate a health profession and recommend whether it should be regulated under the *BCHPA*.[98] If an investigation is carried out, s. 9 the *BCHPA* provides for the following procedure, complete with the power to compel evidence:

> **9** (1) If the council decides to conduct an investigation under section 7 (3) (c) or is directed to conduct an investigation under section 8 to determine whether a health profession should be designated under this Act, it must give public notice of the investigation in the Gazette.
>
> (2) Without limiting an investigation under this Act, the council may do one or more of the following for the purposes of the investigation:
>
> > (a) require the health profession association to provide further information specified by the council;
> >
> > (b) examine the directors and officers of the health profession association;
> >
> > (c) seek the advice of other associations, organizations or persons;
> >
> > (d) if the council considers the action to be in the best interests of the health profession association or the public, hold hearings the council considers necessary in a manner it determines;
> >
> > (e) ascertain what services practitioners of the health profession provide to persons who require care and treatment within the scope of that health profession;
> >
> > (f) evaluate the degree of risk to the health or safety of the public from incompetent, unethical or impaired practice of the health profession;
> >
> > (g) evaluate the degree of supervision that may be necessary or desirable for a person practising the health profession;

[94] *Supra*, note 7.
[95] *BCHPA*, Part I.
[96] *BCHPA*, s. 7(1).
[97] *BCHPA*, s. 7(3).
[98] *BCHPA*, s. 8.

(h) assess the degree of supervision that a person practising the health profession receives or is likely to receive with respect to that practice;

(i) ascertain what educational programs exist in British Columbia or elsewhere for the proper education and training of persons with respect to the practice of the health profession and evaluate the content of those programs;

(j) do other things that it considers necessary and incidental to the consideration of the application or matter before it.

(3) If the council holds a hearing under subsection (2) (d), it may order a person to attend at the hearing to give evidence and to produce records in the possession of or under the control of the person.

(4) On application by the council to the Supreme Court, a person who fails to attend or to produce records as required by an order under subsection (3) is liable to be committed for contempt as if in breach of an order or judgment of the Supreme Court.

It should also be noted that fundamental changes have occurred over the past year in British Columbia affecting the *BCHPA*. In 2002, the *Health Planning Statutes Amendment Act, 2002* [99]was enacted by the British Columbia Legislature. Consequently, as of December 31, 2002, the Health Professions Council ceased to function.[100] In the future, applications for designation under the *Health Professions Act* will be made to the Minister of Health.[101]

**Quebec**

The province of Quebec has developed a 'hybrid' system of health professions' regulation similar to many American jurisdictions. Some health professions are granted an exclusive license to practice (*e.g.*, medicine), while others are granted title protection only.

In June 2002, the Quebec Ministry of Health and Social Services announced changes affecting the way health professions are regulated. In an attempt to modernize the regulation of health professionals, the government reviewed and redefined the scopes of practice of twelve health professions ranging from physicians to physiotherapists. These changes would allow for overlapping scopes of practice between health professions in order to ensure the optimum health promotion and disease prevention of the Quebec population. The government has indicated that the changes would be phased in between January and June 2003. [102]

[99] S.B.C. 2002, c. 15

[100] In email correspondence with staff from the Health Professions Council, it was determined that the dismantling of the Council was due to fiscal constraints being experienced by the B.C. government, rather than an expression of displeasure with the work of the Council.

[101] For a detailed discussion of recent changes to the British Columbia legislation, see: *Proposals to Amend the* Health Professions Act*: Improving Governance and Accountability*, (Ministry of Health Planning: Victoria, B.C., 2002).

[102] Information retrieved on March 26, 2003 from: www.professions-quebec.org/systeme_pro.htm

**United States**

The United States has a patchwork of systems in place to review requests for regulation by health professions.

Reviews of requests for regulation are usually carried out either by legislative committees or an executive branch agency. Some states require that applicant groups provide extensive information in the form of a completed questionnaire. A state audit conducted by the Minnesota Office of the Legislative Auditor has indicated that sunrise provisions may have contributed to a "slow down in the proliferation of occupational regulation."[103] It is worth noting that a common frustration in Minnesota with sunrise reviews is that the recommendations are not always followed by state legislatures.[104]

**United Kingdom**

As previously noted, in the United Kingdom health professions are regulated by a variety of regulatory bodies called Councils. For present purposes, the Council most relevant to the discussion is the Health Professions Council[105] ("HPC") which considers requests for regulation.

Requests for regulation of new health professions are made to the Health Profession Council. Once an application is completed and submitted, a period of public consultation occurs. The HPC then provides its written recommendations to the Secretary of State, at which time it becomes publicly available.[106]

**De-Regulation of Health Professions**

The de-regulation of a profession is, in many respects, simply the obverse of the regulatory coin. The substantive policy reasons for regulation are applicable to the question of de-regulation, however in a negative sense. In other words, if a profession no longer meets the criteria for regulation, then surely its loses its need (and privilege) to be regulated in its current form. Thus, de-regulation may not simply be a matter of "no longer regulated," but rather of being regulated in a different form.

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[103] James Nobles and Roger Brooks, *Occupational Regulation: A Program Evaluation Report* (Office of the Legislative Auditor, State of Minnesota: St. Paul, Minn. 1999) at p. 14.
[104] *Ibid*.
[105] Health Professions Order 2001, SI 254. The HPC replaces the Council for Professions Supplementary to Medicine (CPSM) which was originally established in the 1960's. The HPC is an independent body that reports to the Privy Council, the equivalent of the Federal or Ontario cabinet. The HPC has a chairman, a representative from each of the 12 professions that it currently regulates and 11 lay members. The lay members are appointed by the Privy Council. The HPC is responsible for safeguarding the health and well-being of the public by setting and maintaining standards of professional training, performance and conduct as well as ensuring that registration of professionals is linked to continuing professional development.
[106] It is worth noting that the HPC has legal powers to make recommendations even where a profession has not applied for regulation. These powers can be applied if the HPC felt it was necessary to protect the public. This is consistent with the Crown's right to regulate any profession if it appears that such profession is wholly or partly concerned with the physical or mental health of individuals: *Health Act, 1999*, s. 60(1)(b).

De-regulation is most commonly associated with "sunset" reviews. The purpose of such reviews is to provide the

> process by which a periodic review of specified regulatory agencies is made to determine whether there continues to be a need for the regulation or regulatory body, and, if there is a continuing need, whether the agency is fulfilling its statutory responsibilities in an effective and efficient manner.[107]

Whether such reviews actually achieve their stated purposes is a matter of debate. However, there does appear to be acknowledgement that sunset reviews have been responsible for improvements to regulatory regimes in which they have been used.[108]

**Ontario**

In Ontario, HPRAC has a mandate to provide advice to the Minister on the de-regulation of health professions.[109] However, to date no referral has been made in this regard since the Advisory Council's inception in 1993. In addition, there is currently no legal requirement for regular reviews (sunset or otherwise) of the profession-specific *Acts* in Ontario. In *Adjusting the Balance*, HPRAC's review of the *RHPA* submitted to the Minister of Health and Long-Term Care in March 2001, the Advisory Council recommended "periodic/scheduled reviews" of profession-specific Acts.[110]

**Alberta**

In Alberta, as part of on-going regulatory reform initiatives, all government regulations are being revised to include a "sunset" clause. As regulations expire, ministries are required to review them to ensure they continue to be relevant and current.[111] However, according to staff within the Ministry of Health and Wellness, the *Health Professions Act* is exempt from the sunset review.[112] There is currently no process in place to conduct regular reviews of health profession-specific legislation. Any requests in this regard would need to be initiated by the Minister or professions themselves.

**British Columbia**

In British Columbia, the original mandate of the Health Professions Council included a review of all regulated health professions' legislated scopes of practice to determine their relevance and currency and whether they should be included within the umbrella of the

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[107] *Demystifying*, *supra* note 53 at p. 18.
[108] See generally, *Demystifying*, *supra*, note 53 at pp. 18 – 19; and 1998 Taskforce, *supra* note 69 at p. 30 which, *inter alia*, recommends the adoption of sunset requirements by all states of health care regulation.
[109] *RHPA*, s. 11(1)(b).
[110] *Adjusting the* Balance, at p. 125. At the present time, the Minister of Health and Long-Term Care has not indicated whether the *RHPA* would be amended to include HPRAC's recommendation.
[111] Alberta, *2001-2002 Annual Report*, at p. 53.
[112] Email correspondence of April 2, 2003 with Charlene Crowe, Health Professions Consultant, Alberta Health and Wellness.

new *Health Professions Act* or if there was sufficient justification for them to remain as separate Acts. A significant proportion of the Council's work involved reviewing the regulation of health professions with reference to the following five core principle:

**Mandate of the regulatory body**

- The mandate for health professions has been defined in section 15.1 of the *Health Professions Act* (and has been replicated in each of the other profession statutes).

- Legislative provisions -- including provisions found in regulations, rules and bylaws -- which are outside of those enumerated duties and objects should serve the public interest.

- Barriers to inter-disciplinary practice are not generally in the public interest. The public interest is best served when all related health professions work together collaboratively to maximize the quality and choice of services for the consumer in any field of health care.

- Activities of a regulatory body to promote the economic, political, and professional interests of its members must not compromise the ability of the regulatory body to regulate the profession in the public interest.

**Registration requirements for entry into the profession**

- Principles of administrative law, including natural justice and fairness, must be reflected in the admissions criteria and application process for both new graduates of accredited educational programs and foreign-trained practitioners.

- There must be objective requirements for registration and for accreditation of education programs.

- Applicants should have appropriate rights of appeal of decisions affecting their ability to register.

**Quality assurance measures**

- There should be effective mechanisms for monitoring the continuing competency of practitioners, including the ability to set mandatory continuing education requirements.

- A committee of the board should be responsible for reviewing the standards of practice and code of ethics and circulating new practice guidelines and bulletins to members.

**Complaint and disciplinary processes**

- The principles of administrative law, including natural justice and fairness, should be respected within the regulatory scheme for the handling and disposition of complaints.

- Penalties should be adequate to protect the public.

- Rights of appeal -- whether internal or to the courts -- of decisions following a hearing and decisions not to proceed to a hearing must be available to the complainant and the practitioner.

**Accountability mechanisms**

- There should be a requirement for Government approval of rules or bylaws. [113]

With the winding down of the Health Professions Council at the end of 2002, all policy and process decisions related to the de-regulation of health professions now rest with the British Columbia Minister of Health Planning. The potential impact of these changes, if any, is not yet known. However, there does not appear to be a regularized sunset review process in place.

**United States**

As noted above, the Pew Health Professions Commission's 1998 Taskforce recommended that comprehensive sunset provisions be adopted by each state. The Taskforce argued that these reviews would provide a mechanism for evaluation to ensure that the regulatory bodies were "operating in an effective and efficient manner, providing adequate consumer protection, and that the content of the regulation continues to protect the public".[114] The Taskforce recommended the following criteria be considered in sunset reviews:

> continued regulation by the regulatory body is necessary and, if so, whether it should be changed;
>
> the education, experience, and testing requirements to ensure minimum competence, or whether they place undue burdens on those who want to enter the profession from within or outside the state;
>
> the regulations have any deleterious economic impacts on practitioners, the public and the state's business;
>
> the regulatory program provides accurate, timely and comprehensive information to the public about the qualifications and practice history of the licensed professional;
>
> the practice authority of the regulated profession helps or hinders access to care;
>
> the regulatory program encourages public participation in its policy development;
>
> the regulatory program protects consumers against incompetent, negligent, fraudulent or other illegal acts by licensed professional or unlicensed persons posing as professionals; and
>
> the regulatory body performs its operations, programs and statutory duties efficiently, effectively and expeditiously.[115]

As of 2001, up to 30 states had introduced sunset legislation requiring the automatic termination of regulatory boards and agencies unless legislative action was taken to reinstate them.[116] Many states have included sunset provisions in new laws as well as allowed for the periodic examinations of agencies through performance audits (i.e.

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113 *Terms of Reference: Scope of Practice / Legislative Review of Recognized Health Professions*, Health Profession Council. The Council submitted its final report, *Safe Choices: A New Model for Regulating Health Professions in British Columbia*, in March of 2001.
114 1998 Taskforce, at p. 53.
115 Ibid., at p. 55.
116 Information retrieved on April 3, 2003 from: www.clearhq.org/sunset

legislative or evaluation audits). In some states, the process is carried out through the state auditor's office while in others, a branch of the legislative research agency conducts the reviews.[117] The sunset process is usually accompanied by studies and/or legislative hearings that provide an evaluation of the regulatory program under review.[118]

As previously mentioned, while there is some debate about whether sunset provisions have lived up to their initial expectations, it has been argued that they have led to administrative and structural changes to regulatory boards and agencies.[119] The state of Minnesota's legislative audit found that there have been some reported cost savings, agency improvements as well as increased legislative oversight and an enhanced understanding of boards and agencies as a result of sunset reviews.[120]

**SUMMARY – PART II**

Consideration of the issues associated with requests for regulation have provided the following answers to the basic questions:

Why a request? Changes in technology, science, economics, politics and the intellectual understanding of health care necessitate the evolution and development of new health care professions.

When should regulation occur? When criteria – which are specific aspects of the public interest, have been met that address the public's safety, health and welfare.

What is being requested? Modes and orders of regulation, including a legally recognized and enforceable scope of practice.

Who makes the request? Either the executive or a health profession.

How is the request made? The request is made to either government or its advisory body for consideration. Such consideration includes the application of criteria done through a public consultation process to provide advice to the executive or legislature.

With respect to de-regulation, there are two main points: (1) de-regulation does not necessarily equal no regulation; and (2) sunset reviews are important evaluations in providing indicators for system efficiencies.

[117] *Supra* note 63.
[118] Nobles and Brooks, *supra*, note 103.
[119] *Sunrise, Sunset and Agency Audits*, *supra* note 63; and *Demystifying*, *supra* note 53 at pp.18 – 19.
[120] Nobles and Brooks, *supra*, note 31.

## PART III – REQUESTS FOR A CHANGE IN THE SCOPE OF PRACTICE OF A REGULATED HEALTH PROFESSION

As in the preceding Parts, Part Three will consider the substantive policy and process/procedure issues associated with requests for changes in scope of practice.

### I. SUBSTANTIVE POLICY

**Why is a request made?**

As discussed in Part I, there is a broad consensus among jurisdictions that regulation of health professions is a matter of the public interest and not a profession's interest. Consequently, requests for changes in a profession's scope of practice must be examined with a view to protecting and promoting the public interest.

With the advent of new technologies, and evolving educational programs and accreditation standards, the range of duties and responsibilities being undertaken by many currently regulated health professions are changing as the professions develop. In addition, some health professionals are performing controlled or restricted acts under delegation or with the direct/indirect supervision of another health professional who has those acts within their scope of practice. Thus, with the evolution of a given profession, through these and other means comes the necessity to revise a profession's scope of practice to keep it current and reflective of the actual risk of harm which regulation is intended to address. Moreover, the changing nature of clinical practice from being one of exclusive domain to one of collaborative practice in which practice authority is shared by a number of professions requires that scopes of practice, which provide legal authority, actually reflect clinical reality.

**When is a request made?**

As with requesting regulation, the determining of "when" a request is made is very much a matter that depends upon the requester as well as the evolving political, social, economic and/or professional context in which, and from which, the request is made. Once again, given the existence of known criteria which various regulators have adopted, anyone making a request for a change in scope of practice would at least have to be fairly certain that they had a strong possibility of meeting the criteria.[121]

Requests for changes in scopes of practice are usually initiated by a health profession seeking to incorporate new activities within its current scope of practice.[122] These new activities could be the result of changes in educational programs, accreditation standards, the introduction of new technologies or advances in treatment modalities. The question

[121] It should be acknowledged that the reasons and motives to seek a change in scope of practice are not always as "public interest pure" or criteria driven. As with requesting regulation, a profession may be motivated to seek amendment of its scope of practice for profession-centric reasons such as economic benefit of practice area protection.
[122] 1998 Taskforce at p. 21.

of when to change a profession's scope of practice is related to the profession's ability to fulfill the established criteria. Thus, as with Requests for Regulation, an examination of the public interest criteria in relation to each profession's request is the most appropriate way in which to measure when a change in scope of practice is warranted.

## Ontario

In Ontario, requests for changes in scope of practice can be made when the Minister of Health and Long-Term Care deems it necessary, *e.g.*, the Minister becomes aware of a potential risk of harm, inefficiencies in the current system, or new technologies emerge, *etc*. As with Requests for Regulation, rarely do members of the public initiate a request for change in scope of practice.[123]

The six criteria currently used by HPRAC for assessing a request for change in scope of practice is as follows:

> **Criterion #1 - Protection From Harm**
>
> A principal objective of the RHPA is the protection of the public from harm in the delivery of health care services. The RHPA embodies the protection from harm principle through a number of key provisions and mechanisms such as the harm clause (section 30)[124], the scope of practice regime (including the scope of practice statements for each profession, the controlled acts, the authorized acts and title protection) and the various regulations made under the RHPA.
>
> **Criterion #2 - Quality Care**
>
> The RHPA attempts to ensure that the care provided by individual regulated health care professions is of high quality and that the standard of care provided by each regulated health professional is maintained or improved. This can be seen in numerous provisions in the RHPA such as: entry to practice requirements, competency reviews, patient relations programs and Quality Assurance Committees in the governing Colleges. In addition, Colleges have the authority to make Codes of Ethics for their members, to make regulations about standards of practice and to define "professional misconduct".
>
> **Criterion #3 - Accountability**
>
> Under the RHPA, regulated health professionals are accountable to their patients/clients, Colleges and the public. This accountability is promoted through various provisions in the RHPA such as: the complaints and discipline process, the public's access to information on the register, patient relations programs and the public/professional composition of College Councils.
>
> **Criterion #4 - Accessibility**

[123] To date in Ontario, no matter dealing with a change in scope of practice by HPRAC has been referred based upon an individual member of the public's request. See also 1998 Taskforce at p. 28, which noted the same reality for the American experience.

[124] Section 30 of the *RHPA* provides: No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

> Another public interest objective of the RHPA is that individuals have access to services provided by the health professions of their choice. Further, the Advisory Council understands that the notion of accessibility includes not only access to health professions but also to the regulatory system as a whole.
>
> **Criterion #5 - Equity**
>
> The Advisory Council understands that the principle of equity includes the notions of procedural fairness as well as equalization of benefits or outcomes. The intent of the RHPA was to ensure that all individuals are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. The notion of procedural fairness can be seen in the RHPA by the provisions for: the right to notice and submissions before Committees as well as all procedural and evidential rights under the Health Professions Procedural Code (HPPC) and the Statutory Powers Procedure Act.
>
> **Criterion #6 - Equality**
>
> Equality of regulatory obligations among health care professions is in the public interest. The legislative objective of equality can be seen in the RHPA by the application of a common regulatory framework to all professions, notwithstanding their differences in scope of practice or their overlapping scopes of practice. The RHPA treats all regulated health professions the same and obliges all governing Colleges to adhere to the same corporate structure, purposes and procedures.

In Alberta , while there is not specific statutory provision dealing with changes in scope of practice, s. 23 of the *AHPA* provides that the Minister may ask the Health Professions Advisory Board to give its advice with respect to the *AHPA*.

In British Columbia, the original mandate of the Health Professions Council in 1994, included a review of all regulated health professions' legislated scopes of practice to determine their relevance and currency and whether they should be included within the umbrella of the new *Health Professions Act* or if there was sufficient justification for them to remain as separate Acts. The Terms of Reference for the review included the following with respect to scopes of practice. These should be read in conjunction with the five core principles previously discussion above in Part II:

> 1. How should the existing scope of practice for the health profession be legislatively defined in order to reflect fairly and accurately the current state of practice in that field of health care and reflect the public interest in the practice of the profession?
>
> - The current definition may require expansion and updating to reflect academic/scientific advancements in the practice of the profession and in related professions.
> - A concise legislative definition of the tasks and services appropriately delivered by registrants is required. This should include any limits on the scope of practice that may be necessary for public protection and may involve limits on a class or classes of registrants who have different skills and abilities than other registrants.
> - An aspect of scope of practice may be shared between two or more discrete health professions. [125]

[125] *Supra*, note 113.

**United States**

In the United States, the issue of change in scope of practice is usually addressed under the rubric of "sunrise" reviews. Originally, sunrise reviews were instituted in the 1970's as a means to deal with the deluge of requests for regulation by emerging and allied health care professions. The essence of a sunrise review is to provide a process, either informal or formal, in which the need for, and necessity of, regulation can be addressed. As the process evolved, it has also been adapted to questions of scope of practice review.

For example, in Minnesota, the criteria used in requests for regulation – discussed in Part II, is also applicable to a profession seeking to expand its scope of practice. Another example is provided by Vermont, which considers the following criteria:

> § 3104. Process for review
>
> (a) Either house of the general assembly may designate, by resolution, a regulatory law or an issue that affects professions and occupations generally to be reviewed by the legislative council staff. The staff shall base its review on the criteria and standards in section 3105 of this title.
>
> (b) The review may also include the following inquiries:
>
> (1) the extent to which the board's actions have been in the public interest and consistent with legislative intent;
>
> (2) the extent to which the board's rules are complete, concise and easy to understand;
>
> (3) the extent to which the board's standards and procedures are fair and reasonable and accurately measure an applicant's qualifications;
>
> (4) the way in which the board receives, investigates and resolves complaints from the public;
>
> (5) the extent to which the board has sought ideas from the public and from those it regulates, concerning reasonable ways to improve the service of the board and the profession or occupation regulated;
>
> (6) the extent to which the board gives adequate public notice of its hearings and meetings and encourages public participation;
>
> (7) whether the board makes efficient and effective use of its funds, and meets its responsibilities;
>
> (8) whether the board has sufficient funding to carry out its mandate.
>
> § 3105. Criteria and standards
>
> (a) A profession or occupation shall be regulated by the state only when:
>
> (1) it can be demonstrated that the unregulated practice of the profession or occupation can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is recognizable and not remote or speculative;
>
> (2) the public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
>
> (3) the public cannot be effectively protected by other means.
>
> (b) After evaluating the criteria in subsection (a) of this section and considering governmental and societal costs and benefits, if the legislature finds that it is necessary to regulate a profession or

occupation, the least restrictive method of regulation shall be imposed, consistent with the public interest and this section:

(1) if existing common law and statutory civil remedies and criminal sanctions are insufficient to reduce or eliminate existing harm, regulation should occur through enactment of stronger civil remedies and criminal sanctions:

(2) if a professional or occupational service involves a threat to the public and the service is performed primarily through business entities or facilities that are not regulated, the business entity or the facility should be regulated rather than its employee practitioners;

(3) if the threat to the public health, safety, or welfare including economic welfare is relatively small, regulation should be through a system of registration;

(4) if the consumer may have a substantial interest in relying on the qualifications of the practitioner, regulation should be through a system of certification; or

(5) if it is apparent that the public cannot be adequately protected by any other means, a system of licensure should be imposed.

(c) Any of the issues set forth in subsections (a) and (b) of this section and section 3107 of this title may be considered in terms of their application to professions or occupations generally.

(d) Prior to review under this chapter and consideration by the legislature of any bill to regulate a profession or occupation, the office of professional regulation shall make, in writing, a preliminary assessment of whether any particular request for regulation meets the criteria set forth in subsection (a) of this section. The office shall report its preliminary assessment to the appropriate house or senate committee on government operations.

§ 3107. Information required

Prior to review under this chapter and prior to consideration by the legislature of any bill which proposes to regulate a profession or occupation, the profession or occupation being reviewed or seeking regulation shall explain each of the following factors, in writing, to the extent requested by the appropriate house or senate committees on government operations:

(1) Why regulation is necessary including:

(A) the nature of the potential harm or threat to the public if the profession or occupation is not regulated;

(B) specific examples of the harm or threat identified in subdivision (1)(A) of this section;

(C) the extent to which consumers will benefit from a method of regulation which permits identification of competent practitioners, indicating typical employers, if any, of practitioners;

(2) The extent to which practitioners are autonomous, as indicated by:

(A) the degree to which the profession or occupation requires the use of independent judgment, and the skill or experience required in making such judgment;

(B) the degree to which practitioners are supervised;

(3) The efforts that have been made to address the concerns that give rise to the need for regulation including:

(A) voluntary efforts, if any, by members of the profession or occupation to:

(i) establish a code of ethics;

(ii) help resolve disputes between practitioners and consumers;

(iii) establish requirements for continuing education.

(B) recourse to and the extent of use of existing law;

(4) Why the alternatives to licensure specified in this subdivision would not be adequate to protect the public interest:

(A) stronger civil remedies or criminal sanctions;

(B) regulation of the business entity or facility providing the service rather than the employee practitioners;

(C) regulation of the program or service rather than the individual practitioners;

(D) registration of all practitioners;

(E) certification of practitioners;

(F) other alternatives;

(5) The benefit to the public if regulation is granted including:

(A) how regulation will result in reduction or elimination of the harms or threats identified under subdivision (1) of this section;

(B) the extent to which the public can be confident that a practitioner is competent:

(i) whether the registration, certification, or licensure will carry an expiration date;

(ii) whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement;

(iii) the standards for registration, certification, or licensure as compared with the standards of other jurisdictions;

(iv) the nature and duration of the educational requirement, if any, including, but not limited to, whether such educational program includes a substantial amount of supervised field experience; whether educational programs exist in this state; whether there will be an experience requirement; whether the experience must be acquired under a registered, certified, or licensed practitioner; whether there are alternative routes of entry or methods of satisfying the eligibility requirements and qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met;

(6) The form and powers of the regulatory entity including:

(A) whether the regulatory entity is or would be a board composed of members of the profession or occupation and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure;

(B) the composition of the board, if any, and the number of public members, if any;

(C) the powers and duties of the board or state agency regarding examinations;

(D) the system for receiving complaints and taking disciplinary action against practitioners;

(7) The extent to which regulation might harm the public including:

(A) whether regulation will restrict entry into the profession or occupation:

(i) whether the standards are the least restrictive necessary to insure safe and effective performance;

(ii) whether persons who are registered, certified, or licensed in a jurisdiction which the board or agency believes has requirements that are substantially equivalent to those of this state will be eligible for endorsement or some form of reciprocity;

(B) whether there are similar professions or occupations which should be included, or portions of the profession or occupation which should be excluded from regulation;

(8) How the standards of the profession or occupation will be maintained:

(A) whether effective quality assurance standards exist in the profession or occupation, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics;

(B) how the proposed form of regulation will assure quality:

(i) the extent to which a code of ethics, if any, will be adopted;

(ii) the grounds for suspension, revocation or refusal to renew registration, certification, or licensure;

(9) A profile of the practitioners in this state, including a list of associations, organizations, and other groups representing the practitioners including an estimate of the number of practitioners in each group.

(10) The effect that registration, certification, or licensure will have on the costs of the services to the public. [126]

The Pew Health Commission's 1998 Taskforce has recommended the following four criteria be applicable to evaluate "sunrise" reviews:

1. The change in the authority to practice provides a benefit to the public (choice, access, quality, or costs) without unreasonable risks;

2. The purposed regulation is flexible enough to accommodate changes in technology;

3. The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

4. The public cannot be effectively protected by other means in a more cost-effective manner.[127]

### What is being requested?

The type of changes to a profession's scope of practice will depend upon the nature of the scope. For example, it could relate to a new controlled act or authorized act, or it could be a question of protecting a new title.

In addition, it should be noted that changes to a profession's scope of practice can also have a variety of impacts on other actors and institutions in the health care marketplace as previously discussed in considering Regulatory Themes and Requests for Regulation.

## II. PROCESS/PROCEDURE

### Who makes the request?

As previously noted, in Ontario, as with requests for regulation, anyone can make a referral to the Minister of Health and Long Term-Care requesting a change in scope of practice. The *RHPA* indicates that "the Minister shall refer to the Advisory Council any

[126] Title 26, *Professions and Occupations*, Chapter 57, *Review of Licensing Statutes, Boards and Commissions.*
[127] 1998 Taskforce, at p. 54.

issue … that a Council or person requests the Minister to refer…"[128] However, the most likely actor to request a change in scope of practice would be either the regulatory body, such as a College, or a professional association.

The Minister may also, under s. 11(1) initiate a request, and ask for the Advisory Council's advice on whether a profession's scope should be changed.

In other jurisdictions outside Ontario, the issue of who asks for a change is left either to the executive branch if advice is required, or to regulated professions themselves who seek to change their scope of practice.

**How is the request made?**

**Ontario**

At present under the *RHPA*, professions requesting a change in their legislated scope of practice must submit a request to the Minister of Health and Long-Term Care. The Minister may then refer the matter to the Advisory Council for a review.[129] In its review process, the Advisory Council undertakes an examination of the public interest objectives of the *RHPA* – protection from harm, quality care, accountability, accessibility, equity and equality – in order to develop its recommendations to the Minister.

In 1999, the Advisory Council developed a policy document which outlined the process and the criteria to be used by the Advisory Council in providing its advice to the Minister of Health and Long-Term Care regarding requests for changes in scope of practice under the RHPA. For ease of reference, a copy of this document is attached at Appendix E.

**Alberta**

Similarly, the Alberta Health Professions Board developed a draft policy document outlining the criteria to be used by the Board when making its recommendations on whether to expand the scope of practice of a regulated health profession. The Board requires applicants to submit an activity description, an outline of required competencies and a description of any conditions that may be imposed upon the performance of the activity. The Board then undertakes an assessment of the public interest including the risk of harm, effectiveness and a cost-benefit analysis.

**British Columbia**

As indicated above, in British Columbia, the original mandate of the Health Professions Council in 1994, included a review of all regulated health professions' legislated scopes of practice to determine their relevance and currency and whether they should be included within the umbrella of the new *Health Professions Act* or if there was sufficient

[128] *RHPA*, s. 12.
[129] The Advisory Council has conducted seven such reviews since its inception in 1993. A complete list of HPRAC reports can be found at www.hprac.org

justification for them to remain as separate Acts. A significant proportion of the Council's work involved reviewing the scopes of practice of regulated health professions.[130] The Council's criteria has been discussed above.

With the recent changes in B.C., it is not clear what processes will be in place to review requested changes in scope of practice.

**United States**

The licensure scheme of professional regulation in the United States can perhaps best be described as adversarial in nature. Any changes to a profession's legislated scope of practice require a change in legislation which it turn will have an impact on other professions. It has been argued that the state legislative is overrun with "turf wars" by professions competing over a limited numbers of patients and even more limited health care dollars.[131] Given the overt political nature of the process, it is not surprising to find that lobbying - both for and against, by professions is a key component of the process.[132]

The following example from Title 26 of Vermont's statutes serves to gives an indication of the typical process involved:

> § 3104 Process for Review
>
> (c) The legislative council staff shall give adequate notice to the public, the board and the appropriate professional societies that it is reviewing a particular law and board. Notice to the board and the professional societies shall be in writing. All information required under section 3107 of this title and data reasonably requested for purposes of the review shall be provided by the boards. The staff shall seek comments and information from the public and from members of the profession or occupation. It also shall give the board a chance to present its position and to respond to any matters raised in the review. The staff, upon its request, shall have assistance from the department of finance and management, the auditor of accounts, the attorney general, the director of the office of professional regulation, the joint fiscal committee or any other state agency.
>
> (d) The legislative council staff shall file a separate written report for each review with the speaker of the house and president of the senate and with the chairman of the appropriate house or senate committee as provided in subsection (f) of this section. The reports shall contain:
>
> (1) findings, alternative courses of action, and recommendations,
>
> (2) a copy of the board's administrative rules, and
>
> (3) appropriate legislative proposals.
>
> (e) The legislative council staff shall send a copy of the report to the board affected, and shall make copies available for public inspection.

[130] A full list of HPC reports can be found on the website of the B.C. Ministry of Health Planning at: http://www.healthplanning.gov.bc.ca/leg/hpc/reports.html
[131] Taskforce 1998, at pp. 25 - 26.
[132] For example, in 1997 over 1,600 bills were introduced into legislatures which provided much opportunity for political lobbying, Safriet, *supra*, note 22 at p. 303.

> (f) The house and senate committees on government operations shall be responsible for overseeing the preparation of reports by the legislative council staff under this chapter.
>
> (g) After considering a report each committee shall send its findings and recommendations, including proposals for legislation, if any, to the house or to the senate, as appropriate. Any proposed licensing law shall be drafted according to a uniform format recommended in the comprehensive plan.

In an attempt to move away from a politicized process, the state of Hawaii, in 1990, utilized an ADR (Alternative Dispute Resolution) process to address a scope of practice dispute between Psychologists and Psychiatrists when the latter sought to enlarge their scope of practice to include prescription of drugs to their patients. The legislature utilized an independent third party to act as a facilitator. The object of the ADR process was to produce a "single text" document which contained all the arguments, data, sources *etc*., from testimony from individuals involved in the dispute. Through a number of facilitated hearing, at which professional associations, consumers, and members of the professions participated, the necessary text was produced. In using an ADR process of "neutral fact-finding" the legislative attempted to gather sufficient information on which to make its decision, the criteria of which involved an assessment of the competencies of psychologists to prescribe drugs.[133]

**SUMMARY – PART III**

Consideration of the issues associated with requests for changes in scope of practice have provided the following answers to the basic questions:

Why a request? Changes in technology, science, economics, politics, education, accreditation standards and the intellectual understanding of health care necessitate the evolution and development of currently regulated health care professions.

When is a request made? When criteria – which are specific aspects of the public interest, have been met to a sufficient degree that address the public's safety, health and welfare.

What is being requested? Primarily changes to the Modes of regulation.

Who makes the request? Either the executive, a health regulatory authority, or a health profession.

How is the request made? The request is made to either government or its advisory body for consideration. Such consideration includes the review of criteria through a public consultation process which provides advice to the executive or legislature.

[133] At the end of the day, the legislature decided that the psychologists had not proved their competence with respect to prescribing drugs. For a discussion of the Hawaii experience, see: 1998 Taskforce 1998 at p. 31.

## PART IV – TRENDS AND EMERGING ISSUES

This fourth and final Part will offer a number of observations relating to the identification of emerging issues/trends respecting requests for regulation/deregulation and changes in scope of practice. It is recognized at the outset that this concluding Part will raise many more questions than it will answer, and as such will serve the ends of being a bridge to the Advisory Council's own Discussion Paper on the revisions of the criteria for Requests for Regulation and Changes of Scope of Practice documents.

Based on a review of the literature and the analysis herein, the following nine trends and emerging issues in health professions' regulation/de-regulation and changes in scopes of practice present themselves for consideration:

- Telemedicine/cybermedicine – is one of the most recent examples of regulatory concern *vis-à-vis* how it will effect a profession's scope of practice and the potential for collaborative practice to be utilized.

- Collaborative scopes of practice among a variety of health professionals – is increasingly become of paramount concern given changing clinical realities in terms of both education, accreditation standards and institutional settings.

- "Sunset" legislation – while it may not have accomplished what it was set up to do, there is a growing recognition of a need for it. Such reviews may result in the realization that other regulation may be more appropriate then what is in place. In other words, sunset reviews invite the question of whether a profession needs to be regulated in another way; that is; is there a more *appropriate* way in which to regulate the activity given the cost/benefit analysis of regulation and risk of harm?

- Economic issues – cost/benefit analysis of regulation – how does one measure "costs" and/or "benefits" to profession, consumers and taxpayers?

- Public Interest – despite problems of definition, it remains *the* justification for regulation. Accordingly, the criteria functions as a benchmark of public interest in a specific context is becoming more important.

- Changing educational environment – education is evolving as are accreditation standards based upon that education; how does evaluate the education as a means of evaluation regulatory fitness?

- Regulation of a profession – really a question centered upon efficacy of profession's treatment modalities and its relationship to harm. The relationship between risk of harm and efficacy remains debatable.

- Regulatory theory - a continuum of possibilities from least regulation possible vs. most regulation, which in turn provides for a variety of modes and orders for regulation; which seems to suggest that there may not be one right answer, but a

possible number of right answers to the problems facing health care regulation. Conversely, it may equally be true that in the absence of one or more right answers, there are definitely wrong answers which ought to be avoided.

# Appendix A

## Search Strategy – Health Search

Between February and April 2003, HealthSearch was hired to conduct a thorough search of Medline and HealthStar databases as well as regular "Current Awareness" scans.

The following keywords were searched for the issue of Regulation / De-regulation:

1 audiologist:.tw. (252)
2 speech language pathologist:.tw. (254)
3 chiropodist:.tw. (43)
4 chiropractor:.tw. (441)
5 dietician:.tw. (204)
6 massage therapist:.tw. (22)
7 medical laboratory technologist:.tw. (21)
8 medical radiation technologist:.tw. (15)
9 occupational therapist:.tw. (990)
10 optician:.tw. (76)
11 optometrist:.tw. (561)
12 physical therapist:.tw. (869)
13 physiotherapist:.tw. (875)
14 psychologist:.tw. (2577)
15 respiratory therapist:.tw. (227)
16 *dental assistants / or *dental hygienists / or exp *dental technicians / (1972)
17 regulati:.mp. (30199)
18 exp *CERTIFICATION / (2985)
19 *LICENSURE / (871)
20 deregulat:.mp. (571)
21 regulatory polic:.mp. (140)
22 sunset legislat:.mp. (1)
23 regulatory trend:.mp. (10)
24 regulatory issu:.mp. (207)
25 credential:.mp. (2329)
26 (1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16) and (17 or 18 or 19 or 25 or 21 or 22 or 23 or 24) (210)
27 limit 26 to (english language and yr=1989-2002) (178)
28 Comparative Study / (371507)
29 27 and 28 (12)
30 limit 29 to (english language and yr=1990-2002) (12)

The following keywords were searched for the issue of Scope of Practice:

1 audiologist:.tw. (431)
2 speech language pathologist:.tw. (393)
3 chiropodist:.tw. (59)
4 chiropractor:.tw. (578)
5 dietician:.tw. (270)
6 massage therapist:.tw. (26)
7 medical laboratory technologist:.tw. (25)
8 medical radiation technologist:.tw. (19)
9 occupational therapist:.tw. (1468)
10 optician:.tw. (129)
11 optometrist:.tw. (895)
12 physical therapist:.tw. (1424)
13 physiotherapist:.tw. (1224)
14 psychologist:.tw. (4186)
15 respiratory therapist:.tw. (313)
16 *dental assistants/ or *dental hygienists/ or exp *dental technicians/ (4861)
17 legislat:.mp. (54981)
18 legislative process:.mp. (139)
19 sunset legislat:.mp. (2)
20 exp *Professional Practice/ (73014)
21 scope.mp. (12002)
22 *Lobbying/ (1200)
23 (1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16) and (17 or 18 or 22) and (20 or 21) (45)
24 limit 23 to (english language and yr=1990-2003) (19)
25 from 24 keep 1-6,8,13,15,17-19 (12)

The conditions placed on the searches were as follows:

- articles published from 1990 to present
- English language only

The databases searched were:

- HealthStar and
- Medline

# Appendix B

## Search Strategy – Internet Search

An Internet search was conducted using the Lycos and Google search engines.

Keywords searched:

Health profession regulation
Self-regulation, health professions
Criteria for regulation
Sunrise legislation
Sunset legislation
De-regulation, health professions
Scope of practice, health professions
Regulatory policy
Regulatory trends
Regulatory issues
Occupational and professional regulation
Health, self-regulation

Information collected via the Internet is referenced at various points throughout the paper.

# Appendix C

## Search Strategy – Quicklaw and Lexis-Nexis

A search of key Canadian, American and U.K. law journals was conducted using the Quicklaw and Lexis-Nexis online research services.

Quicklaw provides access to 2,500 databases and Lexis-Nexis provides access to over 33,000 databases.

**Keywords searched:**

Health profession regulation
Self-regulation, health professions
Criteria for regulation
Sunrise legislation
Sunset legislation
De-regulation, health professions
Scope of practice, health professions
Regulatory policy
Regulatory trends
Regulatory issues
Occupational and professional regulation
Health, self-regulation

Appendix D

# HPRAC Policy Document - REQUEST FOR REGULATION

under the *Regulated Health Professions Act, 1991*

## REQUEST FOR REGULATION PROCESS

The Advisory Council is committed to conducting a review of the issues put before it based on evidence available on the public record.

Please note this process is the general approach taken by the Advisory Council, however, the circumstances surrounding a particular application may warrant an alteration of the process. Applicants will be given notice of any alterations from this standard process.

### Procedures

1. A request to regulate a profession under the *Regulated Health Professions Act, 1991* (RHPA*)* should be made in writing to the Minister of Health. The request should include a concise rationale for regulating the profession and a request for the Minister to refer the matter to the Advisory Council. A copy of the letter should be sent to the Advisory Council.

2. Following receipt of the Minister's referral, the Advisory Council will provide the applicant with a "Request for Regulation" package which includes a description of the criteria for regulation and a series of questions. The response to this package should be completed and submitted by a specified date.

3. Applications about the same or related professions may be considered jointly by the Advisory Council, at its sole discretion.

4. Notice of the Advisory Council's review of the request for regulation will be published in the newspaper(s) used for government notice, through the Advisory Council's mailing list and posted on the Advisory Council's website.

5. Notice of the review of the request for regulation may be made in other publications or other media where warranted.

6. Following notice, individuals or organizations interested in the review should inform the Advisory Council that they wish to participate in the review process.

7. All participants will be provided with a copy of the applicant's completed "Request for Regulation" package and informed of the review process including the deadline for written submissions and the method of distribution of submissions to other participants.

8. The purpose of written submissions is to comment on the regulation of the profession in general and to respond to the completed "Request for Regulation" package.

9. The applicant and all participants will be afforded an opportunity to provide a written response to any of the submissions from other participants.

10. Following receipt and analysis of all written submissions, the Advisory Council will inform participants whether public presentations are deemed necessary. Participants will be asked to indicate if they are interested in making a public presentation.

11. The purpose of public presentations is for participants to respond to issues raised in the written submissions of other participants and to respond to specific questions of the Advisory Council.

12. Public presentations will be at the invitation of the Advisory Council and will be selected from among those participants indicating an interest in presenting. The Advisory Council will control the presentation proceedings including setting the agenda and adhering to time allotments for presenters. The Advisory Council will strive to achieve a balance in presenters.

13. Presentations will be held in open meetings unless issues involving public security or personal safety and health suggest to the Advisory Council that the public should be excluded. All presentations will be recorded and transcribed.

14. Simultaneous translation, signing, large print, and other accommodation will be available on request. All public meetings will be held in wheelchair-accessible space.

15. The Advisory Council may consult with experts, collect data or conduct literature reviews or use any other process for obtaining information it deems necessary. The results of such investigations will be made public before the presentations or before the final deadline for submissions.

16. Persons or organizations with identified expertise may be invited, at the discretion of the Advisory Council, to make presentations. The Advisory Council will provide adequate notice to ensure that all may respond to these presentations.

17. The Advisory Council will consider supplemental submissions containing information relevant to the request for regulation for up to four weeks following the presentations.

## Access to Information

18. Upon written request, the Advisory Council will provide copies of:
    - completed “Request for Regulation” package
    - submissions in response to the “Request for Regulation” package
    - submissions from any experts engaged in the process
    - minutes from meetings with individuals/organizations participating in the review
    - supplemental submissions

19. The Advisory Council is subject to the *Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.F. 31* , including the protection of personal privacy.

## Recommendations

20. The Advisory Council's recommendations will be based only on the Council’s assessment of the profession’s ability to meet the criteria for regulation.

21. The Advisory Council will present its recommendations in an Advisory Memorandum to the Minister of Health.

22. The Advisory Council’s recommendations are and remain confidential unless they are released by the Minister of Health.

## Completing and Submitting the REQUEST FOR REGULATION

1. Responses to the request for regulation should be typed and, if possible, provided on a disk using WordPerfect or MSWord software to:

   **Health Professions Regulatory Advisory Council**
   **2195 Yonge Street, 4th Floor, Toronto, ON M4S 2B2**

2. Four copies of the "Request for Regulation" and required supporting documentation should be submitted for review. Once the Advisory Council is satisfied the "Request for Regulation" is complete and the number of participants is identified, applicants will be advised of the total number of copies required.

3. The review of the request for regulation will only commence if the Advisory Council is satisfied, at its own discretion, that all nine criteria have been addressed and all supporting documentation has been submitted.

# APPLICANT'S INFORMATION

## For all Applicants

1. Profession for which regulation under the *Regulated Health Professions Act, 1991* is being sought
2. Name of the association/group/individual making the request
3. Address/website/e-mail (if available)
4. Telephone and facsimile numbers
5. Contact person (including day telephone numbers)
6. List the other organizations in Ontario (including address and contact person if known) which represent practitioners in similar or related areas of health care
7. List other professions, organizations or individuals who could provide relevant information with respect to the practice of your profession

## For Associations

8. Names and positions of the directors and officers
9. Length of time the association has existed as a representative organization for the profession
10. List name(s) of any national or international association(s) for this profession with which your association is affiliated
11. Provide your association's:
    - Certificate of Incorporation
    - Constitution and bylaws
    - Code of ethics
    - Standards of Practice
    - Policies and procedures
    - Audited financial statements for the last five years
    - Membership list, if public.

# Profession's Information

# Criterion #1

## Relevance to the Minister of Health

A substantial portion of the profession's members are engaged in activities that are under the jurisdiction of the Minister of Health and the primary objective of the treatments/services they provide is the promotion or restoration of health.

**Questions:**

1. Who are the users of the profession's services?

2. Explain how the promotion or restoration of health is the primary objective of the profession's treatments/services.

3. What is your profession's relationship with the Ministry of Health? (e.g. funding, serving on Ministry committees etc.)

4. The numbers of practitioners working in the following settings (estimation):
    a) institutional settings: e.g. hospitals, nursing homes, homes for the aged, Independent Health Facilities (clinics)
    b) community settings: e.g. public health, Community Health Centres (CHC), Health Service Organizations (HSO), Community Care Access Centres (CCAC), other community agencies
    c) private practice: solo or with colleagues
    d) private practice with other regulated health professionals
    e) other

# Criterion #2

## Risk of Harm

A substantial risk of physical, emotional or mental harm to individual patients/ clients arises in the practice of the profession.

**Questions:**

5. Define what practitioners of the profession do. Specify what diagnoses (if any) and assessments they make. Specify the treatment modalities and services they provide.

6. Specify the diagnostic tools, equipment, and methods used by practitioners of the profession.

7. Specify areas of practice, treatment modalities, and services which are:
   a) Performed exclusively by practitioners of the profession
   b) Also performed by other regulated health professions
   c) Also performed by other unregulated health professions
   d) Performed in conjunction with other regulated health professions
      i) Provide specific information about the nature and extent of any overlaps in practice with other health professions. *Include references to, and copies of, scientific literature and other published information.*
      ii) Provide specific information about which treatment modalities and services provided by your practitioners differ from other health professions. *Include references to, and copies of, scientific literature and other published information.*

8. What professional titles do you recommend be restricted to members of your profession?

9. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health profession?

10. Specify which diagnoses/assessments, treatment modalities and services entail a risk of harm to patients/clients.

11. To what extent has the public's health, safety or well-being been endangered because your profession has not been regulated?
    a) Provide examples of patients/clients being harmed by a practitioner who performed services incompetently or inappropriately. *Include references to, and copies of, scientific literature and other published information*.
    b) How many complaints of harm to patients/clients has the association received each year for the past 10 years? How were complaints handled? What were the outcomes? Provide supporting documentation.

12. How will regulation decrease the substantial risk of harm of your profession's treatments/services to patients/clients?

13. To your knowledge, what percentage of practitioners of the profession normally carries liability insurance coverage? Does the association require its members to carry liability insurance coverage?

# Criterion #3

## Sufficiency of Supervision

A significant number of practitioners of this profession do not have the quality of their performance monitored effectively, either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professions who assign this profession’s services.

**Questions:**

14. Are practitioners of the profession directly or indirectly supervised in the performance of their duties and responsibilities by other regulated practitioners or administrators of regulated institutions? Which particular tasks/services, if any, are subject to a greater or lesser degree of supervision?

15. Are practitioners of the profession currently performing controlled acts under the delegation of regulated professionals?

# Criterion #4

## Alternative Regulatory Mechanism

The profession is not already regulated effectively or will not soon be regulated effectively under some other regulatory mechanism.

**Questions:**

16. Are individuals who practise this profession in Ontario subject to regulation restrictions found in any other Act? Please specify.

17. Should self-regulation be determined not appropriate for your profession, what would be the most appropriate alternative form(s) of regulation? How might other applicable laws or existing standards meet your profession's needs?

18. What Acts in other Canadian jurisdictions regulate the profession? What is the statutory scope of practice in these jurisdictions? Please provide copies of all these statutes and regulations.

19. What Acts in American jurisdictions regulate the profession? What is the statutory scope of practice in these jurisdictions? Please provide copies of as many of these statutes and regulations as possible.

20. What Acts in other International jurisdictions regulate the profession? What is the statutory scope of practice in some of these jurisdictions? Please provide a sample of these statutes and regulations.

# Criterion #5

## Body of Knowledge

The members of this profession must call upon a distinctive, systematic body of knowledge in assessing, treating or serving their patients/clients. The core activities performed by the members of this profession must be discernible as a clear and integrated whole and must be broadly accepted as such within the profession.

**Questions:**

21. Briefly describe the core body of knowledge of the profession.

22. Please provide a proposed scope of practice and relate it to this body of knowledge. *Include references to, and copies of, scientific literature and other published information*.

*For the following question, provide the rationale for your position including relating each to the body of knowledge, educational preparation and standards of practice. Also include references to, and copies of, scientific literature and other published information providing evidence for your argument and rationale.*

23. With respect to your proposed scope of practice statement:
    a) What controlled acts (if any) should members of the profession be authorized to perform?
    b) What specific acts should practitioners be permitted to delegate to others? Specify the circumstances when members of the profession may choose to delegate.
    c) What diagnostic/treatment modalities and services should members of the profession be permitted to perform?
    d) What are the limitations of practice (if any) for members of the profession? Are there any acts within this field of health care which practitioners should not perform? What diagnostic/assessment abilities, treatment modalities and services are not part of the scope of practice for members of the profession?

# Criterion #6

## Educational Requirements for Entry to Practice

To enter the practice of the profession, the practitioner must successfully complete a post-secondary program offered by a recognized educational institution. The educational program must be available in Canada.

Governing bodies may register individuals from other jurisdictions with equivalent training, in compliance with the entry to practice regulation.

**Questions:**

24. Does your association set standards of practice for diagnostic/treatment modalities and services based on the identified body of knowledge? Please explain. Are these standards enforced? Please explain.
*Provide a copy of the standards of practice and ethical guidelines.*

25. Identify and describe the educational and clinical/practical training program(s) available in Ontario. Specify theoretical and clinical/practical experiences.

a) Describe how the profession's body of knowledge and approach to diagnostic/treatment modalities and services are taught in this program.

b) Relate the education and training to the diagnostic/assessment abilities, treatment modalities and services described in Question #5.

c) What percentage of the practitioners of the profession has Ontario education and training?

d) What percentage of the members of the Association has Ontario education and training?

*Provide copies of curricula, calendars etc.*

26. Identify and describe the Canadian academic education and clinical/practical training available to persons seeking to enter this profession. Specify the theoretical and clinical/practical experiences.

a) Describe how the profession's body of knowledge and approach to diagnostic/treatment modalities and services is taught in these institutions.

b) Relate the education and training to the diagnostic/assessment abilities, treatment modalities and services described in Question #5.

c) What percentage of the practitioners in the province has Canadian education and training?

d) What percentage of the members of the Association has Canadian education and training?

*Provide copies of curricula, calendars etc.*

27. Identify and describe the American academic education and clinical/practical training available to persons seeking to enter the profession. Specify theoretical and clinical/practical experiences.

a) Describe how the profession's body of knowledge and approach to diagnostic/treatment modalities and services is taught in these institutions.

b) Relate the education and training to the diagnostic/assessment abilities, treatment modalities and services described in Question #5, if possible.

c) What percentage of the practitioners in the province has American education and training?

d) What percentage of the members of the Association has American education and training?

*Provide copies of curricula, calendars etc.*

28. Identify and describe the International academic education and clinical/practical training available to persons wanting to enter the profession. Specify theoretical and clinical/practical experiences.

a) Describe, where possible, how the profession's body of knowledge and approach to diagnostic/treatment modalities and services is taught in these institutions.

b) If possible, relate the education and training to the diagnostic/ assessment abilities, treatment modalities and services described in Question #5.

c) What percentage of the practitioners in the province has International education and training?

d) What percentage of the members of the Association has International education and training?

*Provide copies of curricula, calendars etc. where possible.*

29. Identify and explain the major differences between programs in different jurisdictions.

30. What academic/vocational/technical education/training, post graduate and continuing education/training is required by:

a) your association for membership
b) employers
c) other Canadian jurisdictions for registration by a regulating body

31. Do you contemplate tiered registration? Please explain.

# Criterion #7

## Leadership's Ability to Favour the Public Interest

The profession's leadership has shown that it will distinguish between the public interest and the profession's self-interest and in self-regulating will favour the former over the latter.

**Questions:**

32. Why is it in the public interest to regulate your profession? Why is your profession seeking regulation?

33. Give evidence of your profession's commitment to the public interest through its communications, policies and/or procedures.

34. Does the association have a complaints and disciplinary procedure? Please describe this briefly. How long has this procedure been in place? How effective has it been?

35. Explain how the proposed scope of practice is in the public interest and provides adequate public protection while not unduly restricting the public's choice of health care providers.

# Criterion #8

## Likelihood of Compliance

The members of this profession support self-regulation for themselves with sufficient numbers and commitment that widespread compliance is likely.

**Questions:**

36. Do the members of your profession/association want self-regulation? Please describe any consultation process. What was the response?

37. Do the other organizations (if any) which represent practitioners in similar or related areas of health care agree with the need for regulation? Please explain.

# Criterion #9

## Sufficiency of Membership Size and Willingness to Contribute

The practitioners of the profession are sufficiently numerous to staff all committees of a governing body with committed members and are willing to accept the full costs of regulation. At the same time, the profession must be able to maintain a separate professional association.

**Questions:**

38. How many persons practise this profession in Ontario (estimate)? How many of these practitioners belong to your association?

39. Explain how the members of the profession will be able to assume the responsibilities, including the expense, of administering their own College?

40. What would be the proposed fee structure for College members?

Appendix E

# HPRAC Policy Document - REQUEST FOR CHANGE IN SCOPE OF PRACTICE

under the *Regulated Health Professions Act, 1991*

## Request for a Change in Scope of Practice

***The Advisory Council is committed to conducting a review of the issues put before it based on evidence available on the public record.***

Please note this process is the general approach taken by the Advisory Council, however, the circumstances surrounding a particular application may warrant an alteration of the process. Applicants will be given notice of any alterations from this standard process.

## Procedures

1. A request to change a profession's scope of practice under the *Regulated Health Professions Act, 1991* (RHPA) should be made in writing to the Minister of Health. The request should include a concise rationale for the change and a request for the minister to refer the matter to the Advisory Council. A copy of the letter should be sent to the Advisory Council.

2. Following receipt of the Minister's referral, the Advisory Council will provide the applicant with a "Request for A Change in Scope of Practice" package. This package includes a series of questions and a description of the assessment criteria, which are based on the public interest objectives of the RHPA. The response to this package should be completed and submitted by a specified date.

3. Applications about the same or related professions may be considered jointly by the Advisory Council, at its sole discretion.

4. Notice of the Advisory Council's review of the request for a change in scope of practice will be sent out through the Advisory Council's mailing list, posted on the Advisory Council's website and may be made in other publications or other media where warranted.

5. Following notice, individuals or organizations interested in the review should inform the Advisory Council that they wish to participate in the review process.

6. All participants will be provided with a copy of the applicant's completed "Request for A Change in Scope of Practice" package and informed of the review process including the deadline for written submissions and the method of distribution of submissions to other participants.

7. The purpose of written submissions is to comment on the proposed change in the scope of practice of the profession in general and to respond to the completed "Request for A Change in Scope of Practice" package.

8. The applicant and all participants will be afforded an opportunity to provide written response to any of the submissions from other participants.

9. Following receipt and analysis of all written submissions, the Advisory Council will inform participants whether public presentations are deemed necessary. Participants will be asked to indicate if they are interested in making a public presentation.

10. The purpose of public presentations is for participants to respond to issues raised in the written submissions of other participants and to respond to specific questions of the Advisory Council.

11. Public presentations will be at the invitation of the Advisory Council and will be selected from among those participants indicating an interest in presenting. The Advisory Council will control the presentation proceedings including setting the agenda and adhering to time allotments for presenters. The Advisory Council will strive to achieve a balance in presenters.

12. Presentations will be held in open meetings unless issues involving public security or personal safety and health suggest to the Advisory Council that the public should be excluded. All presentations will be recorded and transcribed.

13. Simultaneous translation, signing, large print, and other accommodation will be available on request. All public meetings will be held in wheelchair-accessible space.

14. The Advisory Council may consult with experts, collect data or conduct literature reviews or use any other process for obtaining information it deems necessary. The results of such investigations will be made public before the presentations or before the final deadline for submissions.

15. Persons or organizations with identified expertise may be invited, at the discretion of the Advisory Council, to make presentations. The Advisory Council will provide adequate notice to ensure that all may respond to these presentations.

16. The Advisory Council will consider supplemental submissions containing information relevant to the request for a change in scope of practice for up to four weeks following the presentations.

## Access to Information

17. Upon written request, the Advisory Council will provide copies of:
    - completed "Request for A Change in Scope of Practice" package
    - submissions in response to the "Request for A Change in Scope of Practice" package
    - submissions from any experts engaged in the process
    - minutes from meetings with individuals/organizations participating in the review
    - supplemental submissions

18. The Advisory Council is subject to the *Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.F. 31*, including the protection of personal privacy.

## Recommendations

19. The Advisory Council's recommendations will be based only on the Council's assessment of whether the proposed change in scope of practice meets the criteria based on the public interest objectives of the RHPA.

20. The Advisory Council will present its recommendations in an Advisory Memorandum to the Minister of Health.

21. The Advisory Council's recommendations are and remain confidential unless they are released by the Minister of Health.

## Completing & Submitting the "REQUEST FOR A CHANGE IN SCOPE OF PRACTICE" package

1. Responses to the "Request for A Change in Scope of Practice" should be typed and, if possible, provided on a disk using WordPerfect or MSWord software to:

   **Health Professions Regulatory Advisory Council**
   **2195 Yonge Street, 4th Floor, Toronto, ON M4S 2B2**

2. Four copies of the "Request for A Change in Scope of Practice" and required supporting documentation should be submitted for review. Once the Advisory Council is satisfied the "Request for A Change in Scope of Practice" is complete and the number of participants is identified, applicants will be advised of the total number of copies required.

3. The review of the request for a change in scope of practice will only commence if the Advisory Council is satisfied, at its own discretion, that all criteria have been addressed and all supporting documentation has been submitted.

# Applicant's Information

## For all Applicants

1. Profession for which a change in scope of practice under the *Regulated Health Professions Act, 1991* is being sought

2. Describe the change in scope of practice being sought

3. Name of the College/association/group making the request

4. Address/website/e-mail (if available)

5. Telephone and facsimile numbers

6. Contact person (including day telephone numbers)

7. List other professions, organizations or individuals who could provide relevant information with respect to the requested change in scope of practice of your profession

## For Associations

8. Names and positions of the directors and officers

9. Length of time the Association has existed as a representative organization for the profession

10. List name(s) of any national or international association(s) for this profession with which your association is affiliated

# QUESTIONS

Below you will find a series of questions. The Advisory Council will evaluate your responses against the public interest criteria outlined in the next section when formulating its recommendations to the Minister of Health.

HPRAC is committed to conducting an evidence-based review of the issues put before it. Consequently, we would ask that to the extent possible, you provide facts and figures in order to substantiate your viewpoint. *Copies of scientific literature and/or other published information would be appreciated.*

**Questions:**

1. What is the exact wording for the proposed change in your profession's scope of practice and how is the proposed change rationally related to your profession?

2. Why is your profession seeking this change in scope of practice?

3. Why is it in the public interest to change the scope of practice of your profession?

4. Which other regulated and unregulated professions are currently performing this same function? How are they performing it? (ie. under delegation or on their own initiative?, etc.)

5. What health care need in Ontario is underserved by the current scopes of practice among regulated health professions which would be met by your proposed change in scope of practice?

6. What are the costs/benefits to the public and the profession in allowing this change in scope of practice?

7. Would the public's risk of harm be affected (increased or decreased) by this requested change in scope of practice? If so, how do you propose to address it?

8. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health profession both currently and in the context of the proposed change in scope of practice.

9. How do you envision this change in scope of practice being put into place by the College?

10. If the change in scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act.

11. Do members of the profession have the education and training necessary to carry out the duties and responsibilities involved in the proposed change in scope of practice? Please describe the theoretical and clinical/practical experience.

    *Provide copies of curricula, calendars etc. from the appropriate educational institutions.*

12. How do you propose to ensure that members maintain competence in this area?

13. How do you propose to evaluate the membership's competence in this area?

14. How do you propose to educate or advise the public of this change in scope of practice?

15. What is the experience in other Canadian jurisdictions? Please provide copies of all relevant statutes and regulations.

16. What is the experience in American jurisdictions? Please provide copies of as many statutes and regulations as possible.

17. What is the experience in other International jurisdictions? Please provide a sample of relevant statutes and regulations.

18. How, if at all, would this proposed change in scope of practice affect the public's access to health professions of choice?

19. How would the proposed change in scope of practice affect the current members of your profession? Of other health professions?

20. Are members of your profession in favour of this change in scope of practice? Please describe any consultation process. What was the response?

21. If the change in scope of practice results in your profession's scope overlapping with that of another regulated health profession, will that overlapping practice be regulated equally and what will be the impact on your profession vis à vis other professions with the same scope of practice?

# THE PUBLIC INTEREST

With respect to the regulation of health care professions, the Advisory Council believes that the "public interest" is best promoted by adherence to the fundamental objectives of the RHPA. The Advisory Council understands that there are six fundamental public interest objectives that underlie the RHPA. These are:

- Protection from harm
- Quality care
- Accountability
- Accessibility
- Equity
- Equality

# CRITERIA FOR ASSESSMENT

Below you will find the Advisory Council's criteria for assessing a profession's application for a change in scope of practice.

## Criterion #1 - Protection From Harm

A principal objective of the RHPA is the protection of the public from harm in the delivery of health care services. The RHPA embodies the protection from harm principle through a number of key provisions and mechanisms such as the harm clause (section 30)[134], the scope of practice regime (including the scope of practice statements for each profession, the controlled acts, the authorized acts and title protection) and the various regulations made under the RHPA.

## Criterion #2 - Quality Care

The RHPA attempts to ensure that the care provided by individual regulated health care professions is of high quality and that the standard of care provided by each regulated health professional is maintained or improved. This can be seen in numerous provisions in the RHPA such as: entry to practice requirements, competency reviews, patient relations programs and Quality Assurance Committees in the governing Colleges. In addition, Colleges have the authority to make Codes of Ethics for their members, to make regulations about standards of practice and to define "professional misconduct".

[134] No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

## Criterion #3 - Accountability

Under the RHPA, regulated health professionals are accountable to their patients/clients, Colleges and the public. This accountability is promoted through various provisions in the RHPA such as: the complaints and discipline process, the public's access to information on the register, patient relations programs and the public/professional composition of College Councils.

## Criterion #4 - Accessibility

Another public interest objective of the RHPA is that individuals have access to services provided by the health professions of their choice. Further, the Advisory Council understands that the notion of accessibility includes not only access to health professions but also to the regulatory system as a whole.

## Criterion #5 - Equity

The Advisory Council understands that the principle of equity includes the notions of procedural fairness as well as equalization of benefits or outcomes. The intent of the RHPA was to ensure that all individuals are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. The notion of procedural fairness can be seen in the RHPA by the provisions for: the right to notice and submissions before Committees as well as all procedural and evidential rights under the Health Professions Procedural Code (HPPC) and the Statutory Powers Procedure Act.

## Criterion #6 - Equality

Equality of regulatory obligations among health care professions is in the public interest. The legislative objective of equality can be seen in the RHPA by the application of a common regulatory framework to all professions, notwithstanding their differences in scope of practice or their overlapping scopes of practice. The RHPA treats all regulated health professions the same and obliges all governing Colleges to adhere to the same corporate structure, purposes and procedures.