

Commentaries on the Maine Health Care Reform Commission

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The final report of the Maine Health Care Reform Commission (MHCRC) was submitted to Governor King in November, 1995. Given the complexity of what we call the healthcare system as well as the moving targets of federal and state incentives for reform, the report accomplished a great deal in a short period of time.

Commission members were "mandated to offer a single payer universal coverage bill, a multiple payer universal coverage bill, and a bill to achieve reform through incremental changes to the existing system, emphasizing cost containment, managed care, and improved access. The commission was also mandated to cost out its recommendations" (Executive Summary, MHCRC Report).

Reactions to the MHCRC report were invited from individuals who represent constituencies which often have an influential role in healthcare. Five commentaries address pros and cons of particular elements of the commission's report: the first is by David Wihry, an economist at the University of Maine; the second comes from Peter Millard, Clifford Rosen, and Susan Thomas, practicing physicians in Maine; Representative Richard Campbell (r) comments on the development, process, and outcomes of the commission; Elizabeth O. Shorr, Blue Cross and Blue Shield, provides a third-party payer perspective; and Dale Gordon and Kim Boothby-Ballantyne offer a nursing perspective. Adjunct to these commentaries, Senator Dale McCormick comments on the work of the Maine Health Professions Regulation Project and links the efforts of this task force to that of the commission's recommendation to adopt an incremental reform plan in Maine.

Start Making Sense: A Legislator Looks at Professional Licensure Reform

Dale McCormick

This past summer, the Maine Health Professions Regulation Project and its task force released a report to Governor King and the Maine legislature. The report, "Toward a More Rational State Licensure System for Maine's Health Professions," represents the best thinking and accomplishments of a nearly two-year project directed by Judy Kany of Medical Care Development, Inc. My commentary addresses five aspects of this project: the approach of the task force, why licensure reform is necessary, the relationship between this project and the Maine Health Care Reform Commission, the report issued by the task force, and a brief review of the nine "problem areas" and 12 recommendations contained in the report.

Task Force Approach

I highly commend the approach taken by the task force to develop its report and final recommendations. By utilizing a structure that included an advisory group, conferences, committees, and meetings involving more than 2,000 participants, the project and its task force took the lead in modeling the correct approach to reforming the way this state licenses its various healthcare professionals. The 2,000 people involved included providers, institutions, professionals, and bureaucrats (many of whom have something to gain or lose by changing or maintaining the current system), as well as people the report describes as "citizens at-large." This is as it should be. The involvement of the lay public must continue in any process that addresses healthcare system reform issues. The approach used in this case established a basic integrity; if citizen involvement continues through the implementation of the report's recommendations, then the foundational purpose of both licensure and reform--protecting and serving the public--will remain intact.

Licensure Reform

Two questions should be asked: Why is licensure reform needed and how is it relevant to Maine's attempts to achieve real healthcare reform? The public perception of a "licensed professional" is one of guaranteed competence and quality, yet, according to the report, a license only guarantees a "minimal degree of competency," at the time of entry into the profession. In most instances a license does not address the issue of continued competency. In essence, there is a limit to what licensing can guarantee.

In addition, the professionalization of health and medical care services results from two centuries of social, political, economic, and natural forces that have sculpted and defined today's healthcare system. At stake has been who provided it, who didn't, and what healthcare providers called themselves. The resulting quilt features distinct squares and patches we now identify as doctors, nurses, dentists, etc., stitched together, but lacking in overall design or uniformity. The task force recognized the primary weakness in this piece-meal layout: taken as a whole it lacks logical design. It reflects the historic needs and interests of healthcare professionals rather than the public.

As a legislator representing 35,000 Maine residents, I think it's important to acknowledge that the state's healthcare professionals licensure "system" does not make sense when taken as a whole. The task force recognized this need for a more rational system and prioritized the public in developing its recommendations. I applaud the task force for recognizing these fundamental principles in its approach and in its report.

The Project's Relationship to the Maine Health Care Reform Commission

This project and its task force recommendations complements the work of the Maine Health Care Reform Commission. For one thing, professional licensure is a natural tool for healthcare reform. It can be implemented, as the report indicates, in a reasonable, logical fashion, and represents one of many reform increments.

Second, this project, although it could easily stand on its own, directly enhances the work of the Health Care Reform Commission in the areas of quality assurance, public oversight, and health

workforce planning. Again, this project offers a rational approach which focuses on the big picture yet doesn't get overwhelmed by the seeming enormity of systemic healthcare reform. We can use the professional regulation component (or increment) to start making sense of healthcare services, delivery, and financing.

The Health Care Reform Commission's draft recommendations were released at almost the same time as the Maine Health Professions Regulation Project task force recommendations. The commission recommended "state and public oversight through an audit and an open, participatory process." It also recommended several quality assurance approaches, including "report cards" and a state-designed "Quality Improvement Foundation." These recommendations are connected to licensure in several ways because they address issues of professional competence, continuing education, data collection, and consumer protection. The commission's draft does not include its health workforce planning recommendations, so this aspect of shared responsibility is not addressed, but merely alluded to.

LD 1512, The Patient Provider Protection Act, which I'm sponsoring next session, includes several of the suggestions made by the task force. In order to protect patients and providers in a managed care environment, LD 1512 requires that the "Superintendent of Insurance" issue a report card each year comparing managed care plans in several crucial areas including percentage of enrolled children who have been immunized, direct service rates (dollars spent on services to enrollees compared to totals previously paid), provider/patient ratios, and voluntary and involuntary disenrollments. LD 1512 also sets standards for quality assurance. While a national standard is available and referenced by the task force, I'm delighted that the task force is urging a state-designed quality assurance standard since the national standard is minimal.

In general, the legislature will be interested in how Maine can rationally allocate, distribute, develop, and fund healthcare programs statewide. More will be needed from both the Health Care Reform Commission and the Health Profession Regulation Project on the issue of healthcare workforce planning, health service planning, and research and development.

The Task Force Report

I have several observations about the report. First, it is generally understandable and accessible. It contains some professional and bureaucratic language which could be informed by the addition of a glossary of terms for the lay public and media. Mainers will need to be informed in order to express their opinions to legislators and the local media. I encourage the task force to use a variety of avenues to keep lay people involved--public hearings, focus groups, community roundtables, press releases, public service campaigns, and readable, understandable literature. Not only does this provide integrity to the implementation of change in the licensure system, it will lend valuable guidance to the legislature and other decision makers.

Second, the report refers to managed care as a "done-deal," an inevitability. In the short run, this is probably realistic; indeed, it would be foolish to think otherwise given the rapid expansion of managed care. The report cites that: "Before the state employees' health insurance plan moved to managed care April 1, 1993, the market penetration was less than two percent. Today, depending on what is considered a managed care plan, the market penetration is at least 20-25 percent."

...and Medicaid will be moving to a managed care system as well. Nonetheless, let's make sure we have a vision that extends beyond the managed care approach. Managed care is not the end-point of healthcare reform, and we should not build a systemic response that leaves out the possibility for growth in other directions.

Third, the report could say a great deal more about professional ethics, in my mind an integral component of competence. We need to pay a great deal of attention to reducing the attitudes and behaviors that protect unethical practice. The ethics discussion goes beyond sexual exploitation and illegal actions to include such things as billing Medicaid, getting kickbacks for referrals, lying to patients, breaches in confidentiality, ignoring informed consent, and discriminating against certain patients or clients. These obvious ethical transgressions should indicate less than minimal degrees of competence. Healthcare professionals understand that the integrity of their professions depends on ethical vigilance. Hence, professional ethics is both a professional concern and a consumer priority.

Task Force Recommendations

The body of the report contains 12 task force recommendations to the governor and legislature. Together these recommendations call for five broad, essential policy changes:

- Clarifying and streamlining regulatory laws;
- Improving communication and cooperation among health professions and their regulatory boards;
- Requiring professionals to demonstrate continuing competency and increasing the use of modern technology to assist in this process;
- Acknowledging and allowing for overlapping areas of skill and subsequently redefining healthcare provision to reduce or eliminate unnecessary practice monopolies; and,
- Advocating for uniform terminology and standards among states.

The report examines nine specific problem areas. Below I address each problem and the task force's recommended solutions.

Problem area #1. Confusion about different levels of professional regulation and the meaning of terms like "registration," "certification," and "licensure."

This is a simple problem with an equally simple solution. Regulatory terms should be standardized, defined, and easily understandable by 99 percent of consumers. The term "licensure" should be reserved for public regulation of health professions, and efforts should be made to educate both professionals and the public that they serve to ensure their comprehension of regulatory terms. There's no argument against the need to make this change. It is fiscally harmless and will improve both regulation and public protection.

Problem area #2. Maine laws and rules governing health professionals' practice and regulation vary from one profession to another, even when they address the same actions or transgressions.

In this case, the task force calls for a statute that provides uniformity with regard to how incompetence or unprofessional acts are disciplined while allowing individual governing boards to define incompetence and unprofessionalism. The task force encourages simplifying and streamlining the regulatory system to make it more manageable and understandable to professions, managers, payers, consumers, and state bureaucrats. The task force proposed 12 different actions such as creation of a new board to oversee newer, smaller health professions, training regulatory board members, improving public access to information about the complaint and disciplinary process, and improved enforcement.

As a legislator, I am anxious to see implementation of this series of proposals because we need to reduce the confusion about who is responsible for the primary discipline of a health profession and we need to give some teeth to enforcement/disciplinary "watchdogs." We also need to encourage professional whistleblowing; I'd like to see this emphasis included in any statutory proposal. Finally, the proposed actions encourage licensure of more "alternative" forms of healthcare. This is much needed to expand access, increase consumer choice, and protect the public.

Problem area #3. Unnecessary and undue confusion among consumers, payers, and managers because of lack of coordination among health professions.

Although there's been an increased use of multi-disciplinary healthcare, barriers still remain. The organizations, insurance companies, and government systems that finance healthcare work within established borders, limits, and definitions of professional practice. They predicate decisions about what they will pay for on the basis of these distinctions and the consumer is often ill-served. For example, why is dental care excluded and separated from health insurance? For many people, it is their most common and costly healthcare service, affecting their overall physical health. It is the distinction between the practices of medicine and dentistry, as well as more subtle sub-distinctions that create this financing dilemma. Unfortunately, it is the consumers, not the professions, or the payers, who are burdened by this distinction.

If the state department was responsible for coordinating health professions regulation, then some of the confusion regarding the limits of each health profession might be reduced. The department could: foster and nurture inter-professional, multi-disciplinary collaborations; coordinate the review and analysis of proposed rules as well as advise the legislature, governor, and commissioner on these issues; mediate disputes between professions; and develop performance evaluation models for regulatory boards.

A second recommendation in this area calls for the establishment of a "federation of health professions regulatory board," which would include the widening of a staff position within the department, creation of a newsletter and enhancement of other communication tools, training, review of new professions, connecting health information systems with the regulatory system, linking Maine's Emergency Medical Services with other regulatory boards, and public education.

From a legislator's perspective, I favor this integration and coordination; it makes sense. I would like to see more information from the task force on how to pay for some of the proposed activities. I believe this can be accomplished through the current system of using professional fees to pay for professional licensing.

Problem area #s 4 and 5. While minimal competence is guaranteed at the beginning of one's health career, licensure doesn't assure ongoing competence. Even though state law calls for legislative review of potential harm or threat to public safety, if a profession is expanded or unlicensed there is little rational discourse on what actually constitutes a risk.

Problem areas four and five highlight where it's important for the public to understand what licensing does and does not guarantee about a professional's current competency level. The recommendations to establish ongoing, or continued competency through regulatory board requirements is completely logical and serves not only the public interest but also the professions' needs for credibility and authority. If we are going to require continuing competence, then the required statutes or regulations will have to consist of serious enforcement provisions and authority. In establishing a definition of "dangerous healthcare services," let's be clear and uniform. Involving the public in this discussion is helpful, and will improve professional sensitivity and patient confidence. Combining this with promotion of a health professions education system provides more security for the profession and the public, which is always a plus!

Problem area #6. Licensing inadvertently creates or fosters professional monopolies.

Because licensing has traditionally defined who can, or cannot, provide certain services and perform certain functions, we have a system that fails to recognize overlapping skills and competencies. The report proposes four steps to address this issue--that of maintaining the integrity and title of individual professions while allowing for overlapping skills among professions, as well as providing public education so that consumers understand the role of different providers and informed consent.

Revamping "practice acts" will require patience, cooperation, negotiation, and tolerance. The Nurses in Advanced Practice Act, which allows advanced trained nurses to practice autonomously within their scope of practice resulted from a three year turf battle in the legislature between doctors and nurses. Maine consumers can ill afford such protracted fights when there is a shortage of primary providers.

Acknowledging overlapping skills among professions also affords us with an opportunity to integrate a broader array of professions into our vision of the overall healthcare system. We can include professions such as domestic violence counselors, hospice professionals, substance abuse counselors, and "alternative" health professionals. This integration would serve consumer interests well and help protect some of the most vulnerable clients and patients.

Problem area #7. The change to fewer sole practitioners and towards teams and networks should not indicate a change to "institutional licensure" over the individual licensure of professionals.

The project and its task force realistically acknowledged the changes being wrought by healthcare financing, managed care entities, and so on. However, as costs are controlled through new organizational models of healthcare, there is insufficient assurance that the public interest will be protected. The commitment to a regulatory system that mandates the licensure of individual professionals is an iron-clad requirement.

Problem area #8. There is a need for more public understanding and patient/provider partnerships.

This is probably the most rational, common sense section of the report. It is simple; it is clear; it is in the public interest. The recommendation encourages consumers to assume more responsibility for their health and to receive more information and education.

Overall, the report emphasizes the use of newsletters, which are fine for professional communications, however, it should be noted that written material will only be useful for a certain segment of our population. Those who implement this recommendation need to take into account varied levels of literacy and use creative approaches such as video programming and radio/TV public service campaigns to keep the public informed and educated.

A related recommendation emphasizes the use "of modern technology" which is certainly compatible with the direction in which Maine is moving. With one of the best telecommunications infrastructures in the country, we are positioned to utilize several approaches to provide information, education, and even professional training. While the report encourages the development of provider/patient partnerships through the greater use of information technologies, we should recognize the barriers here--that the poorest citizens do not have as much computer background or access to computers. It will be essential for healthcare providers to consider how these technologies can be made available in their communities. Both the legislature and the private sector will have to figure out how to pay for it.

A priority target for consumer education ought to be Medicaid recipients. DHS Commissioner Concannon has spoken about the use of a toll free telephone number for Medicaid recipients to access simple medical help. Rural doctors have also suggested to me that this type of service would provide them with some relief from the 24 hour on-call schedule that they maintain every other day. Telephone access may be a key to educating and informing the public and relates to welfare and Medicaid reform as well as healthcare reform.

Further, if the legislature is going to consider funding some aspects of public education, it should think about an educational approach or program that teaches citizens how to be empowered consumers as well as how to be healthy. We should teach people how to choose a healthcare provider, what questions to ask a professional, how to register a complaint, what the law requires and prohibits, who to call for help, etc.

I applaud the report's suggestions that encourage interaction among professions and wrap-around services. Even more bold is the proposal that patients be informed in advance of the cost of their services. Along with that, there should be more encouragement to expand options for payment: more use of discounts, sliding fee scales, installment plans, barter, etc. When promoting patient/provider partnerships, an honest acknowledgement of the financial aspect of the relationship is required.

Problem area #9. The entire healthcare system is complex. Policy areas overlap and interact; when looking at any one aspect of reform, you have to keep the big picture in mind.

From the legislative standpoint, we have to address the relationships between social policy, federal policy, financing systems, health workforce planning, technology, data collection, and more. The report recognizes this and targets 13 public policy areas including the effects of international trade agreements, malpractice, and other issues, that need to be addressed in the near future. It also suggests that Maine work with other states to develop uniform national entry to practice standards and competency exams.

Implementation of the project's recommendations will hinge on several considerations. The legislature should take a close look at the 1991 Ontario Regulated Professions Act, which the report features as one of its models. There are several questions that need to be answered. How should we address what it will cost to implement these reforms? Which state department should have primary responsibility? What are the private sector's roles and responsibilities? Where does public health fit in and how will the public health profession be included? Should there be a consumer/public advisory board?

The Ontario model may not be a perfect fit for Maine, but it contains five central features to ensure comprehensive consideration, commitment to public protection, and efficient use of all health professionals. Those features are:

- Public protection;
- Improved quality of care;
- Consumer freedom of choice, flexibility, and evolving utilization;
- Openness and accountability; and,
- Policy development;

Governor King, the legislature, and the public should be supporting the implementation of the Maine Health Professions Regulation Project as described in the report of its task force. It is specific enough to give us several years worth of work yet broad enough to consider the needs of the future. It's an essential component of healthcare reform and is consistent in its commitment to both professionals and the public. What could make more sense?



Dale McCormick is a state senator and candidate for Congress in Maine's 1st District. She has been a leader in healthcare and insurance reform and authored the Family Security Act--a universal healthcare system for Maine.

End notes

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