

Scope of Practice Reform: Cost Savings and Patient Empowerment



The Center for
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Introduction

In the United States, healthcare providers are limited in the procedures they can legally provide. For example, nurse practitioners (NPs) and physician assistants (PAs) are prohibited from providing certain routine procedures that their counterparts in other jurisdictions may legally perform. Similarly, in the United States, the current system of pharmaceutical regulation requires patients to obtain a prescription from an authorized provider in order to access even relatively safe and effective drugs such as statins, inhalers, insulin, EpiPens, and birth control. In other countries, pharmacists are legally permitted to prescribe or provide these drugs. These restrictions on the provision of medical services are called scope of practice laws. Scope of practice laws can also include oversight provisions, which require physicians to provide ongoing supervision of NPs' and PAs' work and which can also require that NPs and PAs give supervising physicians access to their patients' records. In contrast to licensing laws, which specify which individuals can practice within a profession, scope of practice laws specify which services members of a profession can provide.

Reforming scope of practice laws in the United States so that pharmacists can provide access to commonly prescribed drugs and so that NPs and PAs and other health workers can prescribe drugs and independently perform a wider range of routine procedures would not only save time and money but would also be a step toward patient empowerment and strengthened patient rights. Meanwhile, there is little or no evidence that changing scope of practice laws would put patients at an increased risk of harm. Rather, the current system exposes patients to unnecessary risk by impeding their access to beneficial medical care, especially during public health emergencies like the COVID-19 pandemic. This concern is especially pressing for patients who live in rural communities and people who do not have access to a primary care provider.

Additionally, when considering scope of practice reform, it is a mistake to look only to the consequences of an expanded scope of practice without also considering the value of patients' and providers' autonomy. Respect for patients' choices is a core commitment in medicine. For instance, healthcare providers are morally obligated to obtain informed consent for treatment, in virtue of the value of patient autonomy. If a provider made treatment decisions for his or her patients, the provider would violate patients' rights. So too, limiting scope of practice policies can violate patients' rights to make informed choices about the nature and conditions of their medical care because these policies prevent patients from making important, intimate, and personal decisions about their health and their bodies by restricting the range of providers patients can see and by limiting patients' ability to seek specific services from their providers. These restrictive policies also violate the rights of health workers by limiting their occupational choices, even though these limits do not promote public health and may in fact undermine it.

Background on Scope of Practice Regulations

This overview of scope of practice legislation considers three key components of healthcare regulation. First, scope of practice restrictions contribute to rising healthcare costs because they artificially constrain who can provide specific services. Constraining the supply of service providers for procedures and practices in healthcare is especially costly because increases in overall healthcare spending in the United States and elsewhere are largely driven by the rising cost of services. Second, many scope of practice policies are unnecessary for promoting public health. Other countries have more liberal approaches to the provision of prescriptions and medical services, and evidence suggests that a more liberal approach needn't compromise care.¹ In the United States, scope of practice policies were historically driven at least as much

1 Jeffery A. Singer and Michael F. Cannon, "Drug Reformation: End Government's Power to Require Prescriptions" (White paper, Cato Institute, Washington, DC, October 20, 2020), <https://www.cato.org/publications/white-paper/drug-reformation-end-governments-power-require-prescriptions.11,16>], "issued":{"date-parts":["2020",10,20]}}, "schema":"<https://github.com/citation-style-language/schema/raw/master/csl-citation.json>"}

by political considerations as they were driven by concern for public health.² Third, scope of practice laws prevent health workers from effectively caring for people during public health emergencies like the COVID-19 pandemic.

Scope of Practice Policies Are Expensive

Scope of practice policies contribute to higher healthcare costs in four ways. First, scope of practice regulations can artificially constrain the supply of medical providers. By increasing the barriers to practicing medicine and narrowing the range of procedures a provider can do, these regulations reduce competition and thereby enable providers to charge more for their services.³ Second, though scope of practice regulations may increase the cost of paying medical providers, they may also cost providers indirectly, through heightened liability.⁴ Third, to the extent that scope of practice policies limit the supply of health workers who can treat routine conditions, they are inefficient because they prevent medical practices from providing a wider scope of care to all patients, encouraging physicians to specialize more narrowly to the exclusion of routine care.⁵ Fourth, restrictive scope of practice policies endanger patients who lack access to medical care due to shortages or for reasons of cost. And if people are unable to access routine, low-cost care and screenings, they may develop conditions that are more expensive later.⁶ Across states, scope of practice policy varies substantially. An analysis of this variation reveals that less restrictive scope of practice policies for NPs are not only safe but can also improve access to care and reduce overall healthcare costs.⁷

Federal policy reform can go a long way toward lowering costs and improving the healthcare system, but large-scale economic or social reforms at the federal level are likely politically infeasible at this time. State policymakers are more constrained, but unlike their federal counterparts, state lawmakers are well positioned to make meaningful changes to their states' scope of practice policies, which could lower costs and improve the quality of care for their citizens.

2 Eli Y. Adashi, "California Dreamin': The Story of Senate (Scope-of-Practice) Bill 491," *JAMA Health Forum*, September 25, 2013, <https://jamanetwork.com/channels/health-forum/fullarticle/2760703#top>.

3 Barbara J. Safriet, "Closing the Gap between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers," *Yale Journal on Regulation* 19, no. 2 (2002): 301.

4 This is because the existing system of scope of practice regulations often requires providers to supervise physician assistants and nurse practitioners, which increases their liability for malpractice suits. For example, McMichael finds that less restrictive scope of practice laws limit physicians' payouts for malpractice suits and lowered rates of malpractice suits, whereas more restrictive scope of practice policies are associated with higher rates of malpractice suits. This is not to suggest that more restrictive scope of practice policies caused physicians to provide more negligent care. Rather, because restrictive scope of practice policies require vicarious accountability, physicians were more likely to be sued for another providers' malpractice. McMichael speculates that the relationship between scope of practice restrictions and malpractice incidence partly explains why less restrictive scope of practice policies are associated with greater access to care and potentially lower costs, without a loss of quality. Benjamin J. McMichael, "Beyond Physicians: The Effect of Licensing and Liability Laws on the Supply of Nurse Practitioners and Physician Assistants," *Journal of Empirical Legal Studies* 15, no. 4 (2018): 732–71.

5 Joshua Freeman, "Family Physicians, Nurse Practitioners, Physician Assistants, and Scope of Practice: Who Will Decide?," *Family Medicine* 51, no. 4 (2019): 305–7.

6 For example, one health worker in California writes, "If we continue along our current path, more and more Californians will need to visit the emergency room for conditions like asthma, ear infections, or flu because they lack a primary care provider." California Health Care Foundation, "Five Ways to Cure California's Doctor Shortage," *CHCF Publications*, January 11, 2019, <https://www.chcf.org/publication/cure-californias-doctor-shortage/>.

7 See, for example, Edward Joseph Timmons, "The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on the Cost of Medicaid Patient Care," *Health Policy* 121, no. 2 (2017): 189–96; Thomas G. Koch and Nathan Petek, "The Effect of Nurse Practitioner Scope of Practice on Health Care Utilization and Health: Evidence from Law Changes and Patient Moves" (Paper accepted for the later-cancelled 18th Annual International Industrial Organization Conference, October 2019), https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=IIOC2020&paper_id=3.

Scope of Practice Rules Have Historically Been Implemented to Limit Competition

Medical regulations are almost as old as medicine.⁸ Early guild systems were justified as a way of ensuring that health workers provided high-quality, ethical care, though historians also note that these regulations were also motivated by economic considerations as high-status physicians sought to prevent lower class barbers and apothecaries from providing medical services without their supervision. American medical regulations, like scope of practice regulations, were developed when the American Medical Association (AMA) was founded in 1847.⁹ The AMA continues to maintain their support for scope of practice restrictions on the grounds that “Patients deserve care led by physicians—the most highly educated, trained and skilled healthcare professionals.”¹⁰

While the explicit justification for restricting the practice of medicine is patient safety, these policies also limit the supply of medical providers and effectively give physicians more control over the health marketplace. Physicians’ interests, especially their interests when mediated through a professional association, do not always align with patients’ interests. Throughout the history of medical regulation in America, professional societies’ actions, at least in part, reflect protectionist efforts to constrain the supply of medical care for the benefit of the narrow group of professionals.¹¹ Though the explicit justification for restricting the practice of medicine is patient safety, this justification is unsuccessful in cases where patients do not clearly benefit from restrictive policies and where patients are harmed by higher prices and limited access. As Mancur Olson writes in his seminal work, *The Logic of Collective Action*, it is much more difficult for groups that are large and diffuse (e.g., patients and potential patients) to organize and advocate for their interests in a democratic system than it is for a small, organized group of people with a narrow interest (e.g., physicians).¹² As a result, policy reflects the interests of groups like physicians rather than their patients.

For this reason, professional associations of providers may play the largest role in improving the prospects for scope of practice reform. In the 1990s nurse practitioners and physician assistants lobbied for an expanded scope of practice for their professions. In some states, these efforts were successful, and the effects of these reforms provide a window into the prospects and potential of scope of practice reform.¹³ Registered nurses, midwives, and dental hygienists have also secured expanded authority to provide care in some states that have enacted scope of practice reform. In all these cases, state lawmakers have upheld their expansion of scope of practice, and there is no clear evidence that patient care has suffered as a result of reform.

8 The Twelve Tables, one of the earliest legal codes, forbid health workers from providing poisons in Table VI Law XIV. This code dates to 450 BC. Early Greek and Christian law forbade providing deadly or abortive drugs. In the ninth century, providers formed medical guilds, and by the tenth century they were engaged in certifying professionals and overseeing medical training. Vivian Nutton, *Ancient Medicine* (New York: Routledge, 2004); Walter Pagel, “Prognosis and Diagnosis: A Comparison of Ancient and Modern Medicine,” *Journal of the Warburg Institute* 2, no. 4 (April 1939): 382–98; John M. Riddle, “Theory and Practice in Medieval Medicine,” *Viator* 5, no. 1 (January 1974): 157–84.

9 At this time, healthcare was relatively unregulated in America, but by the end of the 19th century, the AMA had established medical associations in most states, and by the 1930s, these associations effectively advocated for restrictions on the practice of medicine—restrictions that governed whether providers could advertise their services as doctors or physicians and the services that practitioners could legally provide.

10 “AMA Successfully Fights Scope of Practice Expansions That Threaten Patient Safety,” American Medical Association, accessed November 6, 2020, <https://www.ama-assn.org/practice-management/payment-delivery-models/ama-successfully-fights-scope-practice-expansions>.

11 For example, during the Jim Crow era some states mandated the racial segregation of hospitals and medical societies. The American Medical Association refused to intervene when its member associations refused to admit black physicians to its association and effectively excluded black doctors who were members of the National Medical Association from playing a role in national campaigns for healthcare reform. The American Medical Association also facilitated the marginalization of midwives, many of whom were women of color, pushing women into more expensive hospital birthing environments that were not safer for them or their babies. For further discussion of the AMA and racism see: Yele Aluko, “American Medical Association Apologizes for Racism in Medicine,” *Journal of the National Medical Association* 100, no. 10 (October 2008): 1246–47, [https://doi.org/10.1016/s0027-9684\(15\)31496-6](https://doi.org/10.1016/s0027-9684(15)31496-6). For a discussion of midwives and the regulation of obstetrics see Lauren K. Hall, *The Medicalization of Birth and Death* (Baltimore, MD: Johns Hopkins University Press, 2019).

12 Mancur Olson, *The Logic of Collective Action: Public Goods and the Theory of Groups, Second Printing with a New Preface and Appendix*, vol. 124 (Cambridge, MA: Harvard University Press, 2009).

13 For an overview, see Ying Xue, Zhiqiu Ye, Carol Brewer, and Joanne Spetz, “Impact of State Nurse Practitioner Scope-of-Practice Regulation on Health Care Delivery: Systematic Review,” *Nursing Outlook* 64, no. 1 (2016): 71–85.

Scope of Practice Policies Impede Emergency Responsiveness

In 2020, the United States faced an unprecedented public health challenge as the COVID-19 crisis escalated faster than the health system could adapt to and address the pandemic. In response to the pandemic, the federal government and several states changed their scope of practice policies. The Center for Medicaid Services (CMS) issued guidance relaxing requirements that certified registered nurse anesthetists' practice under the supervision of a physician, enabling them to assess and support emergency patients and critical care patients.¹⁴ CMS also issued waivers permitting NPs and PAs to perform services, order tests, and distribute medications that previously required physician oversight.¹⁵ Additionally, 22 states also relaxed scope of practice restrictions to allow NPs and PAs to practice without collaborative agreements or oversight by other health providers, such as physicians.¹⁶

In the short term, expanding scope of practice for NPs and PAs during the COVID-19 pandemic enabled hospitals to quickly respond to their communities' unexpected and urgent health needs. For example, in a nationwide survey conducted by the American Association of Nurse Practitioners, a majority of nurses reported that scope of practice waivers during the pandemic helped them in effectively treating their patients.¹⁷ The success of temporary expansions of scope of practice regulations during the COVID-19 pandemic not only further demonstrates that existing regulations may be unnecessary for the provision of quality care, but they also demonstrate that restrictive regulations could prevent effective emergency responsiveness. Additionally, reinstating restrictive scope of practice regulations after the pandemic subsides could damage officials' relations with healthcare workers, undermine morale, and express a lack of appreciation for health workers' efforts during the pandemic insofar as it would signal officials' efforts to micro-manage the practice of medicine rather than defer to healthcare providers on questions of patient care.¹⁸

Scope of Practice Restrictions on Specific Professions

In the context of nurse practitioners, 22 states and Washington, DC, currently allow a full practice environment for nurse practitioners.¹⁹ This means that NPs are legally permitted to evaluate and diagnose patients, interpret tests, prescribe drugs (including controlled substances), and manage the course of patient care. NPs' licensing is overseen by the American Nurses Association, which supports a full practice environment for NPs. The National Academy of Medicine, formerly called the Institute of Medicine,

14 "Trump Administration Makes Sweeping Regulatory Changes to Help US Healthcare System Address COVID-19 Patient Surge," CMS press release, March 30, 2020, <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>.

15 Ibid.

16 American Association of Nurse Practitioners, "COVID-19 State Emergency Response: Temporarily Suspended and Waived Practice Agreement Requirements," AANP interactive map, accessed November 6, 2020, <https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements>. American Association of Nurse Practitioners, accessed November 6, 2020, <https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements>. "COVID-19 State Emergency Response: Temporarily Suspended and Waived Practice Agreement Requirements," American Association of Nurse Practitioners, accessed November 6, 2020, <https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements>. "don'tUpdate":true,"noteIndex":16}, "citationItems":[{"id":2200,"uris":["http://zotero.org/users/1009106/items/FKB3Z28V"],"uri":["http://zotero.org/users/1009106/items/FKB3Z28V"],"itemData":{"id":2200,"type":"webpage","abstract":"Alabama According to the fifth Supplemental Guidance Issued April 2 in response to Governor Ivey's State of Emergency Declaration and Executive Orders and the Alabama Board of Nursing: Alabama Practice Settings within Licensed healthcare facility (LHF

17 Sara Heath, "Nurse Practitioners Say Expanded Scope of Practice Key for COVID-19," *PatientEngagementHIT*, August 18, 2020, <https://patientengagementhit.com/news/nurse-practitioners-say-expanded-scope-of-practice-key-for-covid-19>. See also <https://www.aanp.org/practice/practice-related-research/research-reports/nurse-practitioner-covid-19-survey-2>

18 Alden Yaunhong Lai, "Is It Fair? How To Approach Professional Scope-Of-Practice Policy After The COVID-19 Pandemic | Health Affairs Blog," *Health Affairs*, June 29, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200624.983306/full/>.

19 "State Practice Environment." American Association of Nurse Practitioners, www.aanp.org/advocacy/state/state-practice-environment. (Accessed on Feb 22, 2021) see also: Christopher Cheney, "More States Pushing for Autonomy in Scope-of-Practice Battle," *Health Leaders*, May 1, 2019, <https://www.healthleadersmedia.com/clinical-care/more-states-pushing-autonomy-scope-practice-battle>.

also recommends a full practice environment for NPs. Yet other states limit the practice environment for NPs or require physician oversight for NPs. The same is true for other advanced practice registered nurses (APRNs) who, like NPs, typically have a master's degree and advanced clinical experience. In states that limit practice environments in these ways, nurse anesthetists and clinical nurse specialists may also be limited in the care they can provide independently.²⁰

Like nurse practitioners, all states license physician assistants, meaning that all states have claimed the authority to oversee PA practice. In contrast to nurse practitioners, which are permitted to operate independently in some states, all states require physician supervision for physician assistants. In some states, physicians must be physically present, whereas others only require that a physician be available to consult by phone.²¹ Most states give PAs full prescriptive authority, but six states do not.²² In some states, individual medical practices can partly determine the scope of practice for PAs, based on their needs, whereas other states have more uniform requirements.

Every state has a Nurse Practice Act that partly defines nurses' scope of practice and then authorizes a state nursing board to interpret further issues related to nursing and to govern issues related to licensure in collaboration with several professional associations.²³ Nurses' scope of practice is usually defined at a general level and also within specific specialties such as emergency services, intensive care, labor and delivery, or oncology. Because there is less standardization in scope of practice policy for nurses, expanding RNs scope of practice will look different in different contexts, but several states recently expanded nurses' scope of practice authorization in primary care specialties in an effort to provide more consistent and accessible care for patients.²⁴

Like labor and delivery RNs, midwives are also limited by scope of practice legislation in some states. These restrictions on care generally limit women's obstetric autonomy and can result in worse outcomes for women and babies, which suggests that scope of practice restrictions do not always protect mothers or babies.²⁵ As Lauren Hall has documented, obstetric care is very constrained both by policies that prevent midwives and doulas from providing services independently as well as by restrictions on birth centers that provide licensed medical care outside of a hospital setting.²⁶ Hall argues that these kinds of restrictions on obstetric care, as well as certificate of need policies that prevent hospitals from offering intensive care for premature and disabled infants, make it more expensive to have a baby in America and make it more dangerous, too.

Scope of practice limitations are also enforced in dentistry, where state laws limit dental hygienists' and dental therapists' authority.²⁷ In 44 states, dental hygienists require some form of supervision in order to initiate treatment based on their evaluation of patients' oral health needs.²⁸ Nevada, Colorado, Wisconsin, Kentucky, Florida, and Maine do not require authorization from a dentist for the initiation of treatment.

20 Rebecca LeBuhn and David A. Swankin, "Reforming Scopes of Practice" (White paper, Citizen Advocacy Center, Washington, DC, July 2010).

21 This information is based on a guide compiled by Barton Associates, a medical staffing firm. Barton Associates, "PA Scope of Practice Laws: Interactive PA Scope of Practice Law Guide," September 29, 2020, <https://www.bartonassociates.com/locum-tenens-resources/pa-scope-of-practice-laws>.

22 These states are Arkansas, Georgia, Iowa, Kentucky, Missouri, Oklahoma, and West Virginia.

23 Amanda Bucceri, "How Is the Scope of Practice Determined for a Nurse?," *Registered Nursing*, accessed February 7, 2020, <https://www.registerednursing.org/answers/how-scope-practice-determined/>.

24 American Association of Nurse Anesthetists, "State Legislators Push Forward Full Practice Authority for Advanced Practice Nurses," *PR News Wire*, February 6, 2020, <https://www.prnewswire.com/news-releases/state-legislators-push-forward-full-practice-authority-for-advanced-practice-nurses-301000689.html>.

25 For example, Markowitz et al find that "Barriers to practice are neither helpful nor harmful in regards to infant health." Furthermore, "states with no practice barriers have lower rates of induced labor and C-sections." Sara Markowitz, E. Kathleen Adams, Mary Jane Lewitt, and Anne L. Dunlop, "Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?," *Journal of Health Economics* 55 (2017): 201–18.

26 Hall, *Medicalization of Birth and Death*.

27 National Conference of State Legislatures (NCSL) and the Association of State and Territorial Health Officials (ASTHO), "Oral Health Providers Overview," *NCSLSOP*, accessed February 10, 2020, <http://scopeofpracticepolicy.org/practitioners/oral-health-providers/>.

28 Sean G. Boynes and Kathy Bassett, "The Search for Consensus," *Dimensions of Dental Hygiene*, March 10, 2016, <https://dimensionsofdentalhygiene.com/article/the-search-for-consensus/>.

Other states allow some hygienists to initiate treatment, but only if they have completed advanced educational requirements or met extensive clinical experience requirements. Only four states allow dental hygienists to prescribe drugs associated with oral healthcare—Maine, Colorado, New Mexico, and Oregon.²⁹ And only thirteen states formally recognize dental therapists, who provide routine cleaning and preventative care. Yet despite limits on the scope of practice for these oral healthcare workers, expanding their scope of practice authorization is associated with improved oral health outcomes.³⁰ It also potentially lowers some socioeconomic barriers to oral healthcare and other medical care by expanding patient's access to oral healthcare from primary care providers and expanding access to some medical care through oral healthcare providers.³¹

Potential Opportunities for Reform

Since scope of practice laws are costly, often unnecessary, and limit patients' ability to choose the type of care best-suited for their individual needs, these laws ought to be reformed. There are several key opportunities for scope of practice reform relating to prescription policies and clinical contexts, but there are also barriers to reform as well as objections over the expansion of scope of practice for health workers.

Allow NPs and PAs to Practice Independently and Provide More Services

One of the primary barriers to effective scope of practice reform is people's uncertainty about changing health policy from the status quo. Expanding scope of practice for advanced practice registered nurses and nurse practitioners, physician assistants, registered nurses, and dental hygienists would not compromise patients' safety in many cases, but it would reduce the cost of medical services and expand access. These benefits are especially salient for patients who lack access to care in three areas: patients in rural areas, low income or uninsured patients, and patients who seek routine procedures and primary care.

By way of illustration, consider patients who live in rural areas. Even accounting for differences in income, rural patients are less likely to receive preventative medical care such as cervical screening, dental maintenance, and cholesterol care.³² Yet 28 states still prevent NPs from practicing independently, thereby maintaining barriers to access for patients. These policies may endanger patients, since state laws that allow for NP independence are correlated with more access to routine checkups and higher care quality.³³

Low-income patients also benefit from relaxing regulation of medical professions. Retail clinics have recently delivered substantial cost savings for low-income Americans. These clinics are primarily staffed by NPs. In states with restrictive scope of practice regulations, access to retail clinics is limited.³⁴ And in these cases, limits on NPs' and PAs' ability to provide care could potentially prevent states from achieving substantial healthcare savings going forward.³⁵ For instance, NP independence is correlated with less emer-

29 NCSL and ASTHO, "Oral Health Providers."

30 Margaret Langelier, Tracey Continelli, Jean Moore, Bridget Baker, and Simona Surdu, "Expanded Scopes of Practice for Dental Hygienists Associated with Improved Oral Health Outcomes for Adults," *Health Affairs* 35, no. 12 (December 2016): 2207–15, <https://doi.org/10.1377/hlthaff.2016.0807>.

31 Richard J. Manski, Diane Hoffmann, and Virginia Rowthorn, "Increasing Access to Dental and Medical Care by Allowing Greater Flexibility in Scope of Practice," *American Journal of Public Health* 105, no. 9 (September 2015): 1755–62, <https://doi.org/10.2105/AJPH.2015.302654>.

32 Julia T. Caldwell, Chandra L. Ford, Steven P. Wallace, May C. Wang, and Lois M. Takahashi, "Intersection of Living in a Rural versus Urban Area and Race/Ethnicity in Explaining Access to Health Care in the United States," *American Journal of Public Health* 106, no. 8 (June 2016): 1463–69, <https://doi.org/10.2105/AJPH.2016.303212>.

33 Jeffrey Traczynski and Victoria Udalova, "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," *Journal of Health Economics* 58 (2018): 90–109.

34 Julie A. Fairman, John Rowe, Susan Hassmiller, and Donna Shalala, "Broadening the Scope of Nursing Practice," *Journal of the Dermatology Nurses' Association* 3, no. 2 (April 2011): 88–90, <https://doi.org/10.1097/JDN.0b013e3182120038>.

35 Christine Eibner, Peter S. Hussey, M. Susan Ridgely, and Elizabeth A. McGlynn, "Controlling Health Care Spending in Massachusetts: An Analysis of Options" (Technical report series, RAND Corporation, Santa Monica, CA, August 2009). For a discussion of retail clinics, cost savings, and scope of practice regulation see p. 90.

gency room use by patients with ambulatory care-sensitive conditions.³⁶ And loosening restrictions on PAs could expand health systems' capacity in areas where low-income populations are currently underserved.³⁷

More generally, as America faces an aging population, Americans will increasingly encounter limits to access to primary care unless the regulatory limits on the health professions change. A recent systematic review found that expanding NPs' scope of practice could expand access to primary care.³⁸ Others have argued that scope of practice reform is an especially promising solution to unmet needs in elderly populations.³⁹ And if the American health system expands in ways that guarantee health insurance and coverage for all citizens, then public officials must permit more people to provide medical services, both to ameliorate the effects of rationing and to reduce wait times.⁴⁰

Scope of practice legislation also violates providers' rights of occupational freedom. As a case in point, consider scope of practice laws that create impediments to abortion access. As Weitz, Anderson, and Taylor argue, politically motivated scope of practice restrictions prevent PAs and NPs from providing abortion care, which violates what many see as women's right to an abortion as well as "practitioners' rights to provide essential care for their patients."⁴¹ More generally, when NPs work in regulatory environments that allow for more independence, they generally work more hours and are more likely to be self-employed, suggesting that physician oversight requirements prevent NPs from working as much or as independently as they would prefer.⁴² Relatedly, an analysis of NPs' labor market mobility finds that NPs show a clear preference for working in states with less restrictive scope of practice policies.⁴³

Relatedly, scope of practice reform in clinical contexts can also promote providers' wellbeing. Scope of practice reform is associated with greater autonomy for providers, which in turn is associated with increased job satisfaction and lower rates of burnout.⁴⁴ A lower rate of burnout has at least three benefits. The first benefit is that reducing burnout keeps people in a profession or specialty for longer, so patients receive more experienced care. Also, people who do not suffer from burnout are likely to provide better care in general. And preventing burnout is one way to maintain the supply of health workers by preventing people from leaving the profession. Altman, Butler, and Shern note that as medicine becomes more specialized, it is also becoming more interdisciplinary.⁴⁵ Increasingly, healthcare is a collaborative effort, and expanding

36 Traczynski and Udalova, "Nurse Practitioner Independence."

37 E. Kathleen Adams and Sara Markowitz, "Loosening Restrictions on the Scope of Practice for PAs," *Journal of the American Academy of PAs* 32, no. 1 (January 2019): 8–9, <https://doi.org/10.1097/01.JAA.0000550294.83595.b4>.

38 Xue et al., "Impact of State Nurse Practitioner Scope-of-Practice Regulation."

39 For example, some propose pharmacist-led geriatric care as a promising strategy for cost-effective health service delivery in older populations.

Others propose expanding the authority of NPs. Higher concentrations of NPs is correlated with better outcomes for older adults. Erika Boman, Ann-Louise Glasberg, Rika Levy-Malmberg, and Lisbeth Fagerström, "Thinking Outside the Box: Advanced Geriatric Nursing in Primary Health Care in Scandinavia," *BMC Nursing* 18, no. 1 (July 2019): 25, <https://doi.org/10.1186/s12912-019-0350-2>; David I. Auerbach, Carie Michael, Douglas Levy, Pater Maramaldi, Robert Dittus, Joann Spetz, Peter Buerhaus, and Karen Donelan, "Optimal Staffing Models to Care for Frail Elderly Adults in Primary Care and Geriatric Practice," *Innovation in Aging* 3, no. S-1 (November 2019): S66, <https://doi.org/10.1093/geroni/igz038.255>; Felix Wei, Greg Egan, and Karen Dahri, "Pharmacist-Led Geriatric Clinic: A Unique Service for Complex Elderly Patients," *Canadian Pharmacists Journal / Revue Des Pharmaciens Du Canada* 152, no. 6 (November 2019): 367–69, <https://doi.org/10.1177/1715163519864386>.

40 For example, in a recent study of newly-implemented accountable care organizations, the authors identify scope of practice reform and "the general activation of RNs as a key component of providing cost savings alongside improvements in care." Patricia Pittman and Emily Forrest, "The Changing Roles of Registered Nurses in Pioneer Accountable Care Organizations," *Nursing Outlook* 63, no. 5 (September 2015): 554–65, <https://doi.org/10.1016/j.outlook.2015.05.008>.

41 Tracy Weitz, Patricia Anderson, and Diana Taylor, "Advancing Scope of Practice for Advanced Practice Clinicians: More than a Matter of Access," *Contraception* 80, no. 2 (2009): 105–7.

42 Sara Markowitz and E. Kathleen Adams, "The Effects of State Scope of Practice Laws on the Labor Supply of Advanced Practice Registered Nurses" (NBER Working Paper 26896, National Bureau of Economic Research, Cambridge, MA, March 30, 2020), <https://doi.org/10.3386/w26896>.

43 Shishir Shakya and Alicia Plemmons, "Does Scope of Practice Affect Mobility of Nurse Practitioners Serving Medicare Beneficiaries?" (working paper, July 14, 2020), <https://doi.org/10.2139/ssrn.3651399>.

44 Amanda K. H. Weidner, Robert L. Phillips, Bo Fang, and Lars E. Peterson, "Burnout and Scope of Practice in New Family Physicians," *Annals of Family Medicine* 16, no. 3 (May 2018): 200–05, <https://doi.org/10.1370/afm.2221>.

45 Stuart H. Altman, Adrienne Stith Butler, and Lauren Shern, eds., "Removing Barriers to Practice and Care," in *Assessing Progress on the Institute of Medicine Report 'The Future of Nursing'* (Washington, DC: National Academies Press, 2016).

scope of practice regulations will enable more participants in a patients' care to provide whatever services and procedures are necessary without needless delay or bureaucratic approval requirements.

Expanding the scope of practice for APRNs, including NPs, increases patients' access to primary care.⁴⁶ Yet some may be concerned that expanding access to care by granting NPs more autonomy would in some way lead to reduced quality of care. This concern is unfounded in light of the evidence though. For example, in a study in the *Journal of the American Medical Association*, researchers found that there were no significant differences in overall health outcomes or patient satisfaction when expanded scope of practice rules enabled more patients to be treated by nurse practitioners rather than physicians.⁴⁷

Permit Pharmacists to Prescribe and Provide More Pharmaceuticals

Though most scope of practice reform initiatives have focused on clinical care contexts, many of the same reasons in favor of expanding scope of practice policies for healthcare providers in the clinic are also reasons in favor of expanding prescribing authority to pharmacists. The authority to prescribe drugs such as insulin, birth control, Narcan, and epinephrine auto-injectors, varies across state lines. In other countries, pharmacists have the authority to prescribe many drugs that require a prescription in the United States. Existing limits to prescribing power make beneficial drugs less accessible and more expensive, which endangers patients and leads to lower quality of care.

The first opportunity for expanding scope of practice to facilitate pharmaceutical access and affordability relates to expanding the prescribing power of existing health workers. One way to expand access is through a less restrictive scope of practice environment for NPs and PAs, but expanding independence for pharmacists can achieve this, too. States could grant pharmacists broader powers to provide commonly prescribed drugs or to renew prescriptions for drugs without another health workers' authorization.⁴⁸ Elsewhere, I argue that patients have the right to access a range of drugs without a permission slip from a licensed health worker.⁴⁹ There, I argue that expanding rights of self-medication would not only be a more respectful approach to medicine, but it could also reduce healthcare costs and improve care, in part because prescription requirements make accessing potentially beneficial drugs prohibitively expensive for low-income patients. In an influential study on the effect of changing a cold medicine's designation from prescription-only to over the counter, economist Peter Temin found that rates of hospitalization for respiratory illness decreased because patients were able to effectively treat their cold and flu symptoms at home.⁵⁰ At the same time, rates of accidental poisoning did not increase. Moving antihistamines and other routinely prescribed drugs over the counter has had similar effects in most cases.⁵¹

Expanding patients' access to some drugs by empowering pharmacists to prescribe them could be an effective way to improve quality of care and lower healthcare costs. Timmons and Norris find that expanding scope of practice regulations to allow pharmacists to administer and process routine lab tests, may

46 "Study: Expand Nurses' Scope of Practice to Increase Care," *Medical Economics*, January 11, 2012, <https://www.medicaleconomics.com/article/study-expand-nurses-scope-practice-increase-care>.

47 Mary O. Mundinger et al., "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *JAMA* 283, no. 1 (January 5, 2000): 59–68, <https://doi.org/10.1001/jama.283.1.59>; H. C. Sox, "Independent Primary Care Practice by Nurse Practitioners," *JAMA* 283, no. 1 (January 5, 2000): 106–8, <https://doi.org/10.1001/jama.283.1.106>. See also, E. Kathleen Adams and Sara Markowitz, "Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants" (Hamilton Project Policy Proposal 2018-8, Brookings, Washington, DC, June 2018), 9–13.

48 Cannon and Singer, "Drug Reformation," 11, 16, issued: {"date-parts": [{"2020", "10", "20"}]}, "schema": "https://github.com/citation-style-language/schema/raw/master/csl-citation.json"}

49 Jessica Flanigan, *Pharmaceutical Freedom: Why Patients Have a Right to Self-Medicate* (Oxford: Oxford University Press, 2017).

50 Peter Temin, "Realized Benefits from Switching Drugs," *Journal of Law & Economics* 35, no. 2 (1992): 351–69.

51 Cannon and Singer, "Drug Reformation: End Government's Power to Require Prescriptions | Cato Institute," 11, 16, issued: {"date-parts": [{"2020", "10", "20"}]}, "schema": "https://github.com/citation-style-language/schema/raw/master/csl-citation.json"}

decrease the costs of the tests.⁵² Moreover, the demand for lab technicians or pharmacists was not changed by expanded scope of practice because these policies typically expanded access in ways that kept pace with patients' demand for testing. By expanding scope of practice policies, lawmakers partly addressed increased demand for testing by expanding pharmacists' authority. In this way, expansions of scope of practice for lab testing could provide a model for prescribing reform going forward.

Authorize Community Health Workers to Provide Treatment

Public officials may consider expanding scope of practice regulations beyond primary care health providers, such as NPs and PAs, to include other licensed health workers, such as dental hygienists, physical therapists, occupational therapists, and community health workers and social workers. For example, some drugs relate to oral healthcare, and in these cases, just as dental hygienists can provide high-quality healthcare that is comparable to dentists' care in a range of cases, so too may hygienists reasonably prescribe drugs in the course of treatment. Similarly, to the extent that physical therapists provide care that is similar to the care that orthopedists and physical medicine physicians provide, it may be reasonable to extend limited prescribing authorities to physical therapists as well.

An even more revisionary approach would allow community health workers and social workers who address problems related to addiction and mental illness to prescribe some drugs for patients who would otherwise lack access to psychiatric treatment. In many ways, community health workers and social workers address conditions that are similar to the conditions that psychiatrists treat. And in low-income populations, it is often difficult for people in need to access a psychiatrist. Though psychiatrists are in short supply where they are needed the most, social workers can address the scarcity of psychiatric care in some contexts, but they cannot substitute for licensed psychiatric care when it comes to prescribing drugs. Currently, social workers are not permitted to prescribe any medications in any state, even though they often work with populations that are taking psychiatric medications and their work may involve medication management. Expanding social workers' authority to prescribe drugs that are related to their broader practice could potentially facilitate more widespread and affordable access to effective psychiatric care. And for similar reasons, community health workers may also be legally empowered to prescribe drugs that prevent the contagious transmission of diseases, such as vaccines and prophylactic drugs like Truvada, which prevents the transmission of HIV/AIDS.

Another revisionary change to scope of practice policies with respect to drugs would be to move some drugs outside of scope of practice requirements entirely by changing their designation from behind the counter to over the counter. The simplest way to achieve this reform would be for the Food and Drug Administration to change the regulatory status of particular drugs (e.g., low-dose inhalers or heartburn medication). There is evidence from Europe that moving more drugs over the counter could expand access and affordability without compromising safety. In the United Kingdom patients can purchase low-dose statins without a prescription.⁵³ In Ohio, legislators proposed allowing access to EpiPens without a prescription.⁵⁴ And similarly, European countries could likely withdraw existing prescription requirements for drugs like melatonin, without a substantial threat to public safety, given that it is widely available in the United States, even for children.⁵⁵

52 Edward Timmons and Conor Norris, "CLIA Waiver Pharmacy Growth: How Does Broadening Scope of Practice Affect the Pharmacist Labor Market?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, October 2016).

53 Niteesh K. Choudhry and Jerry Avorn, "Over-the-Counter Statins," *Annals of Internal Medicine* 142, no. 11 (June 2005): 910, <https://doi.org/10.7326/0003-4819-142-11-200506070-00009>.

54 Ohio Legislature, *Improve Access to Epinephrine*, HB 101, 132nd Gen. Assemb., effective April 8, 2019, <https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA132-HB-101>.

55 Josephine Arendt, "Does Melatonin Improve Sleep?: Efficacy of Melatonin," *BMJ* 332, no. 7540 (March 2, 2006): 550, <https://doi.org/10.1136/bmj.332.7540.550>; Ingeborg Hartz, Marte Handal, Aage Tverdal, and Svetlana Skurtveit, "Pediatric Off-Label Use of Melatonin: A Register Linkage Study between the Norwegian Prescription Database and Patient Register," *Basic & Clinical Pharmacology & Toxicology* 117, no. 4 (2015): 267–73, <https://doi.org/10.1111/bcpt.12411>.

There is also substantial state-by-state variation in access to drugs, including commonly used drugs such as insulin, birth control, and Narcan. In Utah, pharmacists can dispense birth control without a prescription from a physician.⁵⁶ Access to Narcan pens, which counter the effects of an opioid overdose, can be expanded through state surgeons general or chief medical officers, who can issue universal prescriptions for all residents in a state. Or, states can expand access to prescription drugs by expanding providers' prescribing power for certain drugs, such as methadone.

These models for expanding prescribing authority, which include expanding scope of practice authority for NPs and PAs or moving drugs behind the counter or over the counter, highlight potential opportunities for expanding access to pharmaceuticals in contexts where patients may have an interest in accessing without a prescription. But for some drugs, such as opioids, one may worry that expanded scope of practice policies would contribute to drug addiction or abuse.

Yet restrictive scope of practice regulations are not needed to prevent overprescribing. For one thing, state and federal public health officials closely monitor prescribing practices, which they could continue to do even if more health workers had the authority to prescribe. Also, in places that have expanded scope of practice laws for health workers, researchers found that expanding scope of practice had no relationship to rates of opioid prescribing.⁵⁷ And if anything, expanding community health workers' ability to prescribe drugs that treat mental health conditions, as well as drugs such as suboxone or methadone, could potentially counteract some of the harmful effects of the opioid epidemic, resulting in lower rates of substance use disorder on balance.

Conclusion

Reforming scope of practice laws in medicine is a promising way to expand patients' access to healthcare while lowering costs, without reducing the quality of care. Public officials face three options for expanding existing scope of practice regulations in ways that would benefit patients and also respect patients' and health workers' rights to access and provide medical care:

- Expand the scope of practice permissions for existing health workers, essentially enabling them to prescribe a wider range of drugs and to do a wider range of procedures.
- Expand medical authorities to a wider range of people, including physical therapists, dental hygienists, social workers, and community health workers.
- Reduce the range of services or medical options that are limited by scope of practice regulations by, for instance, moving at least some drugs to over the counter or behind the counter status so that patients would not require a prescription to access them.

In defense of the current system, proponents of the status quo must not only show that the current system promotes access and affordability relative to a wholesale liberalization of healthcare markets, but they must also show that existing politically enforced restrictions are better than moderate, incremental reforms that expand the scope of practice for health workers.

In response to these arguments, proponents of the current system may reply that the evidence in favor of expanded scope of practice does not yet justify reform, on the grounds that there are not yet enough data to show that authorizing more providers to do more things would in fact be safe for patients. Yet this response puts policymakers in a difficult position, because to the extent that they lack sufficient data about

⁵⁶ Utah Department of Health, "New Order Makes Hormonal Contraceptives Available to Utah Women without a Prescription," press release, March 27, 2019, <https://health.utah.gov/featured-news/new-order-makes-hormonal-contraceptives-available-to-utah-women-without-a-prescription>.

⁵⁷ Elissa Ladd, Casey Fryer Sweeney, Anthony Guarino, and Alex Hoyt, "Opioid Prescribing by Nurse Practitioners in Medicare Part D: Impact of State Scope of Practice Legislation," *Medical Care Research and Review* 76, no. 3 (June 2019): 337–53, <https://doi.org/10.1177/1077558717725604>.

the effects of scope of practice reform, it is because those reforms haven't been tried. Also, even if there are risks to authorizing more providers to do more things, public officials who are concerned about these risks could require, at least initially, that providers disclose that they are newly authorized to provide a specific service. This would enable patients to give informed consent to whatever care they received from newly authorized health workers in an expanded scope of practice system.

And there are risks associated with maintaining existing scope of practice policies as well. For example, constraining the supply of health workers risks excluding people from access to healthcare. And maintaining the existing system of scope of practice regulations also makes the health system more vulnerable when demand for health workers increases, such as during pandemics and natural disasters. Scope of practice constraints may also make people reluctant to become health workers, to the extent that health-care jobs that lack independence are less desirable than jobs that give workers more trust and autonomy. Though people often overlook the risks associated with maintaining the status quo, the risks of the current system can exceed the risks of expanded scope of practice policies, especially because the current system is legally mandated, and hence, unavoidable.

Moreover, patients who value the current system are not harmed by an expanded scope of practice. If people prefer to see an MD rather than an NP, they would retain that option if NPs were authorized to open primary care clinics in their states. In this way, even if expanding scope of practice to allow NPs to operate independently did harm some patients, the harm would be avoidable to risk-averse patients who are willing to pay more and wait longer to see an MD. To be clear, there is no evidence that expanding scope of practice in this way would put patients at risk. But even for those who are worried about risks, an incremental approach to reform can address these worries and further reassure people that expanding scope of practice regulations is a safe and sensible policy.

Despite the substantial empirical evidence that an expanded scope of practice for health workers would not endanger patients and that it could reduce healthcare costs, old barriers to scope of practice reform remain. One barrier to effective reform is that even if policies become less restrictive at the state level, billing and reimbursement policies may remain relatively restrictive. If so, then even if some patients may legally see NPs for primary care, for example, if payers do not explicitly recognize NPs as primary care providers, then patients will still lack effective access.⁵⁸ Public payers can set a precedent for recognizing expanded scope of practice policies in their billing and reimbursement policies, or legislators could directly encourage or require insurance providers to provide coverage that reflects updates to scope of practice policies.

Other barriers include the old guilds that consolidated powerful groups and created the current system. For example, Altman, Butler, and Shern write that the main obstacle to expanding scope of practice for APRNs and NPs is opposition from physician organizations like the American Medical Association (AMA).⁵⁹ In order to truly safeguard patients and public health, professional associations like the AMA should reconsider their current resistance to scope of practice reform to recognize the evidence that such reforms would expand patients' access to safe and beneficial medical services.

Today, lawmakers continue to face pressure from these professional organizations, while other professional organizations have emerged to challenge the status quo. The prospects for scope of practice reform depend on whether lawmakers will be willing to reject the status quo in favor of a freer, more affordable health system that expands access without compromising patient care. There is some reason to be optimistic about scope of practice reform going forward. The temporary reforms passed in response to the COVID-19 pandemic demonstrate that scope of practice reform does not endanger patients; rather, it promotes access to healthcare. Recently, the federal government released guidance for state Medicaid

58 Tracy Yee, Ellyn R. Boukus, Dori Cross, and Divya R. Samuel, "Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies" (NIHCR Research Brief No. 13, National Institute for Health Care Reform, Auburn Hills, MI, February 2013), 1–7.

59 Stuart H. Altman, Adrienne Stith Butler, and Lauren Shern, eds., "Removing Barriers to Practice and Care," in *Assessing Progress on the Institute of Medicine Report 'The Future of Nursing'* (Washington, DC: National Academies Press, 2016).

programs that encouraged states to reconsider restrictive scope of practice legislation and certificate of need programs.⁶⁰ Public officials have an opportunity to implement a cost-effective, egalitarian policy that is more respectful of citizens' medical and professional rights and which will promote public health better than the status quo.⁶¹

⁶⁰ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, letter to State Medicaid Directors, "Re: Healthy Adult Opportunity" (SMD#20-001), January 30, 2020, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>.

⁶¹ This recent HHS guidance is based on a 2018 report that emphasized the promise of scope of practice reform and telemedicine as opportunities for reducing healthcare costs. Alex M. Azar, Steven T. Mnuchin, and Alexander Acosta, *Reforming America's Healthcare System through Choice and Competition* (Washington, DC: HHS, DOT, and DOL, December 2018).