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# Legislating Interprofessional Regulatory Collaboration in Nova Scotia

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**Abstract**

To shift health professions regulation from traditional to 'collaborative' self-regulation, Nova Scotia has adopted legislation which will: make all self-regulating health professions members of the Regulated Health Professions Network; mandate the Network to facilitate voluntary collaboration among its members; and enable regulators to work together on investigations of patient complaints, to adjust scopes of practice on an ongoing basis and to adjudicate appeals of unsuccessful applicants for registration. The goals are to give health professions regulation the capacity to enable and support the functioning of interprofessional teams. The legislation was adopted primarily for two reasons: collaborative development and unanimous support by all of the province's self-regulating professions; and alignment with the government's health care reform agenda and its emphasis on collaborative team-based care. Contrary to the approach of several other provinces, the legislation will enable but not require regulators to collaborate on the premise that consensual collaboration is more likely to happen, to be meaningful and to yield tangible benefits. Support for this approach can be taken from the impressive collaborative work on which the legislation is based. Evaluation will be critical, and the five-year review required by the legislation will give Nova Scotia the opportunity to test not only the legislation but the ideas on which it is based. The extent of the legislation's reliance on voluntary process will prove to be either its greatest strength or its greatest weakness.

*Afin de faire passer la régulation des professions de santé du modèle traditionnel à un modèle d'auto-régulation « collaborative », la Nouvelle-Écosse a adopté une législation aux fins suivantes : créer un Réseau des Professions de Santé Régulées incluant toutes les professions auto-régulées; mandater le Réseau pour faciliter la collaboration volontaire entre ses membres; et permettre aux régulateurs de travailler ensemble sur les enquêtes sur les plaintes des patients, sur l'ajustement dans le temps des champs de pratiques ainsi que sur les appels de candidats à l'enregistrement dont la candidature aurait été rejetée. L'objectif est de donner à la régulation des professions de santé la capacité d'encourager et de soutenir le fonctionnement d'équipes interprofessionnelles. Deux facteurs principaux ont rendu possible l'adoption de cette législation : son développement fut collaboratif et soutenu par toutes les professions auto-régulées de la Province; ensuite, elle s'alignait avec les projets de réforme de la santé du gouvernement et l'importance qu'ils donnent à la coopération au sein d'équipes soignantes. Contrairement à l'approche adoptée dans plusieurs autres provinces, la législation autorisera mais n'imposera pas aux régulateurs de collaborer, l'idée étant que la collaboration consensuelle a plus de chance de se produire réellement et de donner des résultats tangibles. Que l'approche rencontre l'approbation peut être démontré par l'impressionnante collaboration ayant travaillé à la préparation du texte de loi. L'évaluation sera une étape critique, et la revue à cinq ans inscrite dans la loi donnera à la Nouvelle-Écosse l'occasion*

*de tester non seulement cette législation mais aussi les idées sur lesquelles elle repose. Le fait que la législation repose essentiellement sur l'engagement volontaire pourra être sa plus grande force ou sa plus grande faiblesse.*

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# 1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

In 2012, Nova Scotia adopted the *Regulated Health Professions Network Act* (RHPNA) (2012 S.N.S., c. 48). The RHPNA is the culmination of six years of work on 'collaborative self-regulation' by the Regulated Health Professions Network, an informal body created by the province's twenty-plus self-regulating health professions, including medicine, nursing, dentistry, pharmacy, optometry, dietetics, social work, occupational therapy and respiratory therapy. As developed in Nova Scotia, collaborative self-regulation is a process in which regulators in distinct professions work together on a voluntary basis to enable better regulation. It is intended to enhance the capacity of regulation to address issues that extend beyond occupational boundaries. Specifically, it is intended to enable interprofessional teams and align regulation with a health care system that delivers care through interprofessional teams (Nova Scotia Regulated Health Professions Network 2011).

The RHPNA will replace the existing informal Network with a statutory Network of all self-regulating health professions, which is mandated to foster and support regulatory collaboration among its members. It will have general authority to facilitate collaboration in areas where statutory authority is probably unneeded: sharing of best practices, training, policy development, and quality assurance.

The RHPNA will also authorize collaboration in three areas where it would otherwise be precluded or limited by existing legislation. First, it will authorize collaborative investigation of patient complaints: this will prevent legal challenges to such investigations and free regulators from the sections in their own statutes which would otherwise prevent them from sharing investigative information with each other. Second, subject to a veto given to the Minister of Health and Wellness, the RHPNA will make regulator agreements on the meaning of overlapping scopes of practice binding on those they regulate and on third parties. It will also authorize the Network to establish a process Network members can follow to have their scopes of practice amended by government without going to the legislature as currently required. Third, under the RHPNA, the Network will be able to establish an appeal process for those who unsuccessfully apply for registration with professions that do not have their own appeal process: again, this is something that would otherwise require the enactment of new legislation. In addition, the RHPNA gives the Network a broad power to (with government approval) make regulations enabling collaboration in other regulatory activities where it would otherwise be precluded or limited by the separate statutes of each regulator.

# 2 GOALS OF THE REFORM

## 2.1 Stated goals

The stated purpose of the RHPNA is two-fold: to improve the regulation of providers by giving it a collaborative interprofessional dimension and to encourage and enable collaboration among providers. Nova Scotia's NDP Government positioned the RPHNA within a broader policy emphasis on interprofessional collaboration as a key enabler of health system improvement (Nova Scotia House of Assembly 2012). The marquis initiative in this broader policy has been the establishment of Collaborative Emergency Centres that provide many of the services that would otherwise be provided by difficult-to-sustain rural emergency rooms (Nova Scotia Department of Health and Wellness 2010).

This positioning echoed the Network's rationale for the RHPNA, which invoked the emphasis on 'multidisciplinary teams' in the Romanow Commission and the 2003 and 2004 health accords. The Network argued that collaborative self-regulation under the RPHNA would have benefits of particular importance in a small province with limited regulatory resources spread among twenty-plus regulators (Nova Scotia Regulated Health Professions Network 2011). It would ensure regulation continued to emphasize each profession's responsibility for patient well-being; facilitate consistent or coordinated approaches to common or shared problems and effective responses to issues beyond the capacity of individual regulators; and support sharing of "experience, knowledge and specialized skill" and of "tangible resources, such as policies, standards, training materials and techniques and procedural manuals". The outcomes would be avoided duplication and a "consistently high standard of regulatory practice and public protection in each of Nova Scotia's self-regulating health professions".

In sum, the logic of the RHPNA is that growing collaboration in the delivery of health care requires growing collaboration in the regulation of providers. It prevents regulation from becoming an "unnecessary barrier or impediment to collaborative team-based approaches to the delivery of health care services" while helping to ensure it "plays a role as one of the enablers of team-based delivery of health care services". Alignment between regulation and delivery models towards collaboration is also important to the protective capacity of regulation. The premise is that as care becomes interprofessional, a regulatory system that is also interprofessional is more likely to provide adequate protection than one that is occupationally bounded.

## 2.2 Implicit goals

Sponsorship of the RHPNA by Nova Scotia's self-regulating professions might suggest an implicit goal of diverting attention from legislative options that would be more limiting of professional autonomy. One alternative would be umbrella legislation that, in five other provinces, brings all regulated health professions under a common statute. The Network addressed the possibility that the RHPNA might be regarded as an attempt to preempt

consideration of such legislation in Nova Scotia by stating that its adoption would not argue for or against umbrella legislation (Nova Scotia Regulated Health Professions Network 2011).

Another implicit goal might be inferred from the leadership of the larger and more established self-regulating professions (medicine, pharmacy, dentistry, and nursing) in the development of the RHPNA. The Network's concern for a consistently high standard of regulation across all professions might reflect a particular concern in these professions for the regulatory capacity of smaller and newer professions, as well as an associated concern about the vulnerability that uneven regulatory capacity could create for the institution of self-regulation.

For government, the RHPNA provided validation for an approach to health system governance that stressed constructive cooperation with providers and their representatives, including unions and professional associations as well as regulators.

# 3 FACTORS INFLUENCING THE HOW AND WHY OF

## 3.1 Getting on the agenda

The RHPNA was adopted because it was developed and supported by all of Nova Scotia's self-regulating health professions. The commitment of the regulators of these professions to the project was encouraged and enabled by policy interest and modest financial support from the Department of Health and Wellness over six years under two different governments, three ministers of health and two deputy ministers. Another factor was the contribution of the Network to other government priorities while the discussion of legislation for collaborative self-regulation was under way, including Nova Scotia's response to H1N1 and the development and implementation of legislation on the registration practices of regulatory bodies (Nova Scotia Regulated Health Professions Network 2011).

## 3.2 Final decision-making

Multiple interacting factors contributed to the final decision to proceed with the RHPNA. These included: policy entrepreneurship of the Network in producing not only an innovative policy idea but draft legislation unanimously endorsed by all Network members; synergies between the underlying thrust of the RHPNA and the government's wider approach to health reform and governance; and the design of the RHPNA, which left potentially controversial issues, such as the modification of specific scopes of practice, to the regulation-making and administrative processes and away from the floor of the legislature.

# 4 HOW THE REFORM WAS (AND IS TO BE) ACHIEVED

The RHPNA enables but does not require collaboration. This reflects two of the guiding principles stated in the Act: first, that "collaboration is most successful when the parties to it enter into it voluntarily", and second, that, "where regulated health professions *agree* to collaborate on regulatory processes, statutory barriers to collaboration should be eliminated" [Emphasis added]. Moreover, the RHPNA explicitly guarantees the "regulatory autonomy of each regulated health profession".

This faith in voluntarism differs from the approach taken elsewhere (Lahey 2012). Considerable work has been done on interprofessional regulation in Ontario and British Columbia. In both, collaboration has become one of the statutory objects of each regulatory body (*Health System Improvement Act* 2007, S.O., c. 10; *Health Professions Act* 1986, R.S.B.C., c. 183). In Ontario, this was on the advice of the body that exists to advise the Minister of Health and Long-Term Care on health professional regulation (the Health Professions Regulatory Advisory Council). Regulatory collaboration now falls within the Minister's broad powers to oversee regulatory bodies under the *Regulated Health Professions Act* (*Regulated Health Professions Statute Amendment Act* 2009, S.O., c. 26).

Nova Scotia regulators argued a prescriptive approach was more likely to produce resistance than collaboration or, at best, 'for show' collaboration. They warned it would become more dependent on oversight over time and divert resources to collaboration carried out for the sake of collaboration (Nova Scotia Regulated Health Professions Network 2011). They claimed that collaboration would happen under an enabling approach because of its usefulness in solving real problems, such as the cost, inconvenience and inconclusiveness of a regulatory system that requires each regulator in receipt of a complaint from a single set of events to conduct separate investigations. Such practically motivated collaboration would demonstrate its value and "become a stronger and more compelling rationale than regulatory oversight ever could be for further collaboration".

Nova Scotia's government did not rely exclusively on such arguments or on the impressive collaborative foundations of RHPNA in deciding to proceed. This is indicated by the inclusion of a provision that requires an 'operational review' of the RHPNA five years after it comes into effect.

# 5 HISTORY AND CONTEXT

- The Romanow Report endorsed the role that 'multidisciplinary teams' could play in improving the access of Canadians to primary and other health care (Romanow 2002).
- Governments made commitments in the 2003 and 2004 health accords to increase the number of Canadians receiving primary care through multidisciplinary teams (First Ministers' Meeting 2003; 2004).
- Under the project called *Interprofessional Education for Collaborative Patient-Centered Practice*, Health Canada funded analysis of the role of health professions regulation

as barrier and enabler of collaborative interprofessional care, which culminated in a Conference Board of Canada report on a new regulatory paradigm, collaborative self-regulation, under which health professions regulators would be responsible for supporting interprofessional practice (D'Amour and Oandasan 2005; Lahey and Currie 2005; Conference Board of Canada 2007).

- In 2007, Nova Scotia's health professions regulators, with the support and participation of the Department of Health and Wellness, formed an informal Network to address issues of mutual interest (Nova Scotia Regulated Health Professions Network 2011).
- Between 2008 and 2012, the Network developed the idea of collaborative self-regulation in three phases, with financial and staff support from the Department of Health and Wellness and policy support from the Dalhousie Health Law Institute. In 2008/2009, it developed a model for the collaborative investigation of patient complaints (Lahey 2009).
- Between 2009 and 2011 it considered collaboration in other regulatory functions and developed design principles for the legislation needed to support collaborative self-regulation. In 2012, the Network developed the RHPNA.
- In 2009, Nova Scotia's NDP Government commissioned D. John Ross to review emergency care in rural Nova Scotia (Ross 2010). Acting on Dr. Ross's recommendation for the establishment of collaborative interprofessional emergency centres became central to the NDP's health care reform agenda. For example, new health services insurance legislation authorizing funding for collaborative interprofessional teams was introduced on the same day as the RHPNA (*Insured Health Services Act* 2012, S.N.S., c. 44). This may help to address one of the other barriers that interprofessional collaboration has faced.

# 6 EVALUATION

## 6.1 Process of evaluation, conducted/planned

The RHPNA requires the Minister of Health to ensure a review of the operation of the Act occurs five years after it comes into effect. This review, which must be tabled in the legislature, should address the success of the RHPNA relative to its stated objectives. There is, however, nothing in the RHPNA on what the review must address or on how or by whom it will be done. This creates uncertainty as to whether the review will promote diligent implementation of the RHPNA and produce useful analysis of the contribution the RHPNA does or does not make to the improvement of provider regulation and the provision of better health care.

### 6.2 Impact evaluation

On September 10, 2013, the RHPNA was proclaimed as in force; it is now the law in Nova Scotia. The impact of the legislation will now depend on how (and if) it is effectively operationalized by regulators. Little or no collaboration may take place. If significant collaboration occurs, evaluation will be critical to understanding the impact it has on the quality of regulation and on the delivery of health care.

Meantime, the adoption of broad enabling legislation for collaborative self-regulation developed by twenty-plus professions is, in itself, a significant accomplishment.

## 7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT Analysis of the Reform

| Strengths | Weaknesses |
|---|---|
| • Takes action on an important issue<br>• Supported by strong contextual factors: high level of buy-in from regulators, good relationships among regulators and between regulators and government, and strong policy momentum<br>• Empowers a process already under way by emphasizing 'carrots' rather than 'sticks'<br>• Broad and enabling design means legislation can be used to enable collaboration in virtually all aspects of regulation with limited or no need for legislative amendment.<br>• Supported by all political parties on relatively neutral political ground | • Based on plausible ideas but not on strong evidential foundations<br>• Limited evidence of support or interest beyond the regulatory bodies<br>• Relies almost exclusively on 'carrots' without 'sticks'<br>• Broad enabling design may limit value of legislation in convincing others of the imperative for change.<br>• Support is at the level of general principles and may give way if disagreements arise about how the RHPNA should be applied or used. |
| **Opportunities** | **Threats** |
| • Tools provided by RHPNA can be used to introduce other kinds of improvements in regulation. | • Misappropriation of the opportunity created by the RHPNA for self-serving ends |

| Opportunities (Cont'd) | Threats (Cont'd) |
|---|---|
| • Collaboration under RHPNA may lead to emergence of a coordinated regulatory system that has strengths of centralized models without weaknesses.<br>• Implementation of the RHPNA may lead to regulatory bodies being more active partners in health system governance in areas such as health human resource planning and quality and patient safety. | • Inertia, apathy, low prioritization of Network business, any or all of which could lead to minimalist, risk-adverse, or passive implementation of the RHPNA.<br>• Passive or active resistance from members of regulated professions, from other professional organizations and from other actors in the health care system (educators, district health authorities, Department of Health and Wellness). |

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