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Regulating in the public interest: Lessons learned during the COVID-19 pandemic

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Abstract

This article has three aims. First, to reflect on how conceptualizations of the public interest may have shifted due to COVID-19. Second, to focus on the implications of regulatory responses for the health workforce and corresponding lessons as health leaders and systems transition from pandemic response to pandemic recovery. Third, to identify how these lessons lead to potential directions for future research, connecting regulation in a whole-of-systems approach to health system safety and health workforce capacity and sustainability. Pandemic regulatory responses highlighted both strengths and limitations of regulatory structures and frameworks. The COVID-19 pandemic may have introduced new considerations around regulating in the public interest, particularly as the impact of regulatory responses on the health workforce continues to be examined. Clearly articulating practitioner practice parameters, reducing barriers to practice, and working collaboratively with stakeholders were primary aspects of regulators' pandemic responses that impacted the health workforce.

Introduction

Health profession regulators in Canada operate under a statutory mandate to protect the public interest. The responsibilities of regulators in fulfilling this mandate generally fall under three pillars: (1) professional oversight, (2) ensuring sustained competence and professionalism, and (3) promoting the provision of high-quality, safe care.[1] Prior to the COVID-19 pandemic, regulation of health professions was increasingly scrutinized as stakeholders questioned whether regulatory frameworks were protecting a modern public.[2-5] As the pandemic unfolded, the strengths and weaknesses of regulatory structures and frameworks were highlighted, particularly around enabling flexible workforce responses and quickly responding to societal needs.[6,7] While the long-term impacts of the pandemic on health profession regulation, the health system, and the health workforce are not yet known, health leaders in various sectors can learn lessons from regulatory responses this critical juncture has begun to impart.[8-11]

In this article, we first reflect on how conceptualizations of the public interest may have shifted because of the pandemic. We then focus on the implications of regulatory responses for the health workforce and corresponding lessons for health leaders and systems as we transition from pandemic response to pandemic recovery. Finally, we identify how these lessons lead to potential directions for future research, connecting regulation in a whole-of-systems approach to health system safety and health workforce capacity and sustainability.

The public interest: A crucial concept reconceptualized during COVID-19

It is difficult to define the public interest because it is socially constructed and meanings attached to the term by governments, regulators, and other stakeholders (that include a range of groups and organizations representing the public and its views) have varied across time and place.[4] In nineteenth-century Canada, the public interest pertained to service provision by qualified (ie, trained and educated) individuals to lessen patient or client harm, ensure adequate health service access, and practise ethically and competently.[4] By the late twentieth century, understandings of the public interest had shifted to place more emphasis on cost containment and efficiency in service provision.[12] More recently, in many countries, the public interest is increasingly conceptualized in terms of efficiency, accountability, transparency in governance, and strict control of professional practice.

While it may be too early to determine precisely how the pandemic has challenged government, regulator, and other stakeholders' interpretations of the public interest,[4] it is clear that the pandemic has introduced new considerations regarding regulating in the public interest.[13] Regulatory practices need to adapt to the digital era in response to new technologies and socio-technical landscapes altering work practices and service provision.[5] The widespread shift to virtual care has altered regulatory activities, with new considerations around consent and privacy;[14] modified complaints investigations and discipline processes;[15] and reformed entry-to-practice requirements to include digital competencies.[16-17] Harmonizing regulation across Canadian

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jurisdictions, particularly in the era of virtual care, has taken on new and heightened significance as an aspect of protecting (or serving) the public interest.[18-19] In addition to technology, increased interjurisdictional mobility of health professionals and care provision across borders contributed to shifts in how regulation can protect, promote, and serve the public interest.[2]

Pandemic responses by regulators concentrated on risk management to ensure sufficient access to the health workforce while maintaining public protection.[6] In some Canadian and American nursing regulatory contexts, serving as well as protecting the public was apparent as risk-based or right-touch regulatory approaches were used to reduce regulatory barriers and ensure proportionality of responses during an unprecedented time and demand on the health workforce.[13,20] Originating in the United Kingdom,[21,22] right-touch regulation is used to determine the minimum regulatory action required to achieve a desirable result,[21] and in doing so, match regulatory responses and intervention level to the specific situation.[23] It is based on the principles that regulation should be: proportionate, consistent, targeted, transparent, accountable, and agile.[21] Regulatory shifts in thinking about the public interest during the pandemic extend beyond the behaviour and competence of practitioners to "broader public interest issues" such as health system inequities, workforce planning, practitioner mental health, and racism within healthcare.[13]

The impact of pandemic regulatory responses on the health workforce

Responses to the pandemic by regulators and governments impacted the health workforce significantly, changing "how and where they worked" and "how that work was regulated."[24] The ability to make health workforce changes and facilitate coordinated responses varied internationally and was impacted by regulatory frameworks and systems.[24] Coordinated health workforce responses were difficult to facilitate with Canada's more rigid, subnational regulatory structures. While changes to legislation and policies were required to enhance flexibility within health system labour markets, regulators and employers clearly articulated practitioner practice parameters.[24] For example, Canadian nursing regulators provided nurses with guidance around standards and scopes of practice, advised nurses about redeployment[25] and the duty to provide care,[26,27] and detailed how the standard of care would be considered when nurses were working in extreme or unusual pandemic-induced circumstances.[13,28]

In contrast, regulatory frameworks and regulators in the United Kingdom and Australia facilitated coordinated and more flexible health workforce pandemic responses, but also required the health workforce to assume more responsibility for professional conduct even if dictated by employers. In these countries, scope of practice guidance emphasized exercising professional judgement and practising accordingly.[29,30] It was up to practitioners to identify what was included within their scope of practice when working in challenging pandemic conditions.[31] Practitioners received varying levels of support or guidance from regulators in this regard,[10] and while this flexibility may have aided some workforce responses, it may have left some practitioners concerned about potential liability for individual decisions around scope of practice.[24]

Health professionals in independent practice, such as physicians, are responsible for determining and assessing their competency and learning needs[32] despite some evidence suggesting consistent inaccuracies with "personal global assessments of performance…in a variety of contexts."[33] When regulators or employers place this expectation on practitioners without sufficient guidance, practitioners may feel unsupported and experience additional stress in daily practice,[13] especially during an unprecedented, unsettled global event that has adversely impacted the health workforce.[34-37] Moreover, empirical studies indicate accurate self-assessment of competence is unreliable in particular contexts.[33] Furthermore, pressure on practitioners is amplified if they are expected to be reactive to guidance or directives that continue to change and to make informed (scope of) practice choices with insufficient time to consider their competence and self-efficacy.[24] This predicament can also compromise quality care, safe practice and patient safety, thus providing less protection for both practitioners and patients.

In addition to scope of practice changes and guidance around standards, many regulators focused on reducing barriers to practice to support workforce responses during the pandemic.[13] To strengthen health system responses, increase health workforce capacity and improve equitable access to services during COVID-19, the right-touch principle of "regulatory agility"[13]—the ability and willingness to adapt, pivot, and shift regulatory responses—was crucial, especially within rapidly changing emergency situations.[13,38] Internationally, regulators governing the health workforce demonstrated this agility by incorporating several strategies in their pandemic responses, such as scope of practice expansions and task shifting, changes to facilitate virtual care, recruitment and fast-tracked licensing of certain cohorts (eg, final year trainees, new graduates, and out-of-region or country health workers), flexible return to practice for workers on leave or recent retirees, and building capacity with specific continuing competency and other educational offerings to support task shifting and scope of practice shifts beyond usual practice parameters.[38]

Enhancing in-person and virtual mobility of health workers and services, often impeded by inflexible regulatory structures, can contribute to flexibility in health workforce practices and the ability of individual practitioners and health teams to respond to crises.[38] Reforms to facilitate cross-jurisdictional licensure and virtual care provision have become prominent topics of discussion in Canada and the United States.[18-19,39] Interjurisdictional mobility of the health workforce within

and between countries[5,13] and interjurisdictional virtual care[16,17] may be enhanced through occupational licensing reforms, such as the expansion or uptake of licensure compacts and national licensure,[39,40] federal regulation of telehealth where appropriate, and licensing or registration options specific to telehealth.[40] A new pilot project for interjurisdictional registration for virtual care for registered nurses in Alberta and Saskatchewan and movement toward national databases of registration data using unique identifiers are important steps in the right direction,[13] but more needs to be done to support the harmonization of regulation across borders for all health professions.

Lessons for health leaders and systems

Responses to this pandemic raise important questions for health leaders when supporting health systems and workers during a public health emergency: are employers or regulators better positioned to oversee and institute scope of practice changes for the health workforce? How is competence in an area best defined—is entry-to-practice training sufficient, or is the demonstration of continued competency essential? How can continued competency requirements (eg, mandatory continuing professional development) support quality assurance of the workforce and future responses to crisis and what is the appropriate role for educators and employers in supporting these requirements? Did regulatory flexibility for continuing competence and education requirements[13,41] compromise patient safety, or did it foster much-needed curriculum content and delivery innovation?

COVID-19 is the most recent public health emergency that has required regulators to adapt their policies, processes, and practices. The global scale of COVID-19, the immense pressure placed on regional and national health systems and workforces, and the speed at which the virus spread meant that regulators had to respond quickly with little opportunity to prepare. Previous crises may have provided limited learnings for health system stakeholders, or perhaps learnings were generated but, for various reasons, not applied during COVID. However, in one of our recent research studies, two nursing regulators identified drawing upon previous disaster management experience and emergency crisis training during COVID-19.[13] Preparation for future emergencies with a focus on personnel, resources, protocol and contingency plan creation, coalitions and training has been identified in recent guidance for healthcare leaders.[42] As part of broader disaster or emergency management plans, regulators should develop protocols in collaboration with governmental and non-governmental stakeholders to enable workforce surge capacity while maintaining standards to ensure patient safety.[43] These plans can include focusing on fast-tracking registration and licensure decisions, providing clear emergency or limited registration criteria, and explicitly modifying specific standards of practice as needed for emergency circumstances.

A positive consequence of COVID-19 is that it generated learnings and fostered opportunities[44] to improve regulatory and workforce responses by more comprehensively understanding the complex dynamics and interactions involved.[45,46] Health profession regulators and other health leaders are exploring "innovative regulatory pathways," and giving serious consideration to options they might have been hesitant to implement to "facilitate the availability of crucial [health resources] in an emergency."[8] These changes may include a stronger focus on interprofessional, interdisciplinary, and intersectoral training and regulation to avoid perpetuating siloed education and regulatory systems[47] in a desired future of team-based care and enhanced scopes of practice. Such models of care may require continuing professional development offerings and exploring credentials that enable task shifting and enhanced practice scopes. The COVID-driven need to collaborate with health system stakeholders both within and outside regulators' jurisdictions can be considered a positive development during the pandemic,[13] creating "re-energized relationships" as regulators worked with others to ensure safe and high-quality care.[10] This momentum of collaborative work, and the public interest role of health profession regulators in workforce responses, should not be lost as we move toward post-pandemic health systems.

Future directions for regulatory research

The health workforce is a priority for COVID-19 health services and policy research.[48] At the time of writing, we are more than two years into the pandemic. It is critical to continue examining how the health workforce was deployed and supported to deliver care and barriers and enablers to effective whole-of-system pandemic responses.[8,49-52] Regulators had to make expedited decisions without knowing what the impact of those decisions on the public interest might be.[13] It is important to assess and evaluate the impact on trainees, providers and patients of reactionary decisions that modified entry-to-practice and continuing competence requirements (eg, fewer practice hours and clinical placements, incomplete curriculum, delayed certification and licensing exams, and increased reliance on simulation-based training), and licensure reforms (eg, creation of temporary and emergency classes of licensure) to determine what did and did not work well.[13] This evaluation will help determine whether it is in the public interest to retain specific regulatory changes long-term or instead reserve certain regulatory strategies for emergency circumstances (or not at all).

Future research should prioritize partnered approaches between regulators, researchers, and other health system stakeholders, including health leaders, educators, and the public, with a particular focus on evaluating regulatory outcomes and using regulatory data to improve health workforce planning in both steady-state and emergencies. Such investigations can contribute to a growing body of work focused on evaluating the impact of regulatory policies and processes on improving the safety, quality, and sustainability of the health workforce.

Conclusion

Pandemic regulatory responses highlighted both strengths and limitations of regulatory structures and frameworks. This commentary reflected on how the pandemic may have introduced new considerations around regulating in the public interest, particularly as we continue to examine the impact of regulatory responses on the health workforce. Clearly articulating practitioner practice parameters, reducing barriers to practice, and working collaboratively with stakeholders were primary aspects of regulators' pandemic responses that affected the health workforce. These responses raise critical questions for health leaders supporting health systems and workers in a post-pandemic future and emphasize the importance of evaluating the impact of regulation on health workforce capacity and safety.

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