Respectfully submitted by the undersigned organizations:

* American Academy of Physician Assistants
American Association of Dental Examiners
American Association for Respiratory Care
American Association of State Social Work Boards
American Occupational Therapy Association
American Physical Therapy Association
American Society of Clinical Pathologists/Board of Registry
American Speech Language-Hearing Association
Commission on Dietetic Registration for the American Dietetic Association
Federation of Chiropractic Licensing Boards
Federation of State Boards of Physical Therapy
Federation of State Medical Boards
International Association of Boards of Examiners in Optometry
National Association of Boards of Examiners for Nursing Home Administrators
National Association of Boards of Pharmacy
National Board for Certification in Occupational Therapy
National Council of State Boards of Nursing

State Medical Boards: Institutional Structure and Board Policies

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Overview: *The challenge is to identify characteristics of institutional arrangements that constrain special-interest groups from influencing outcomes in ways that reduce benefits to consumers of physician services. Economists and political scientists have examined characteristics of board arrangements and have some knowledge of the effect on board policy.*

The organizational structure of state agencies affect public policy. For state medical boards, it is their licensing and disciplinary functions which are likely affected. Each state medical board is an agent of its state legislature. Legislators who seek public support have an incentive to establish boards that, with little monitoring, will produce an outcome to please their constituency (voters and, by their ability to generate votes for the legislator, campaign contributors).

Physicians, patients, provider organizations, and others with a stake in health care markets are affected by and attempt to exert influence over the decisions of the board. Consequently, it is interesting to consider if specific arrangements and rules that govern board actions leave some board structures more subject to influence by specific groups than others. Armed with this knowledge, it may be possible to set rules that thwart interest groups' attempts to seek policies in conflict with the interests of the broader population.

As readers of this journal are aware, institutional structures of medical boards vary across states. One need only glance at Section 3 of the Federation's *Exchange* to see the substantial variation in board structure across states.[a] The *Exchange* includes tables that catalogue aspects such as boards' status within state structures, funding sources, board membership—composition, length of term, and whether nominated or appointed. Some boards have relative autonomy, both in budgeting and decision-making, while others do not. The disciplinary structures also differ across states with, among other things, variations in mandatory reporting of violations, sanctions, and standards of proof to which disciplinary procedures are held.

The challenge is to identify characteristics of institutional arrangements that constrain special interest groups from influencing outcomes in ways that reduce benefits to the public. With respect to medical licensure, work by Kessel (1958, 1970) and Svorny (1987), show physician groups have been

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successful in influencing board policies. Changes in health care organization and delivery may put health maintenance organizations in this position in the future. The supposed board customer, whose interest is to be protected, may be the least heard in the political process. The result is board efforts that are less than optimal in terms of maximizing the well-being of the population.

Given the incentives facing interest groups to mold the regulatory process to their own purposes, these groups always will have disproportionate influence over the political process. Nevertheless, economists and political scientists have examined characteristics of board arrangements and have some knowledge of the effect on board policy. This paper begins with a brief description of several theories of agency behavior. A discussion of the empirical research on the consequences of particular rules and organizational structures for agency behavior follows.

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Agency Behavior

The most naive view is that agencies and their officials act in ways to benefit society. In contrast, some theorists suggested that board members would be "captured" by the industry they serve. Industry representatives have the most to gain by influencing board actions and are most likely to make the effort. In some industries, there is evidence that members of regulatory boards are rewarded for initiating policies that benefit the industry with post-agency employment opportunities in the regulated industry.

More recent work by George Stigler and Sam Peltzman stresses the competing influence of industry, consumer, and other groups in the regulatory process. The costs and benefits of organizing (ie, joining forces to instigate policy initiatives) are thought to determine the influence of any particular special interest group. An important insight into the observed disproportionate influence of special interest groups reveals that these groups have much to gain if regulations are crafted to their benefit. In contrast, consumers' interests may be less well-represented when legislative changes impose only a small cost on each consumer.

The distribution of costs (weakly on each consumer) and benefits (strongly on each physician) results in unbalanced lobbying efforts and, therefore, regulatory outcomes that are likely to favor physicians.

For example, physicians benefit from legislation that reduces competition for their services. Limits on the scope of practice of competing providers (physician assistants, midwives, and other health professionals) may increase physician earnings, as will state rules which limit the entry or practice of foreign-trained physicians. Where such restrictions exist, consumers pay more for medical care, but the increment is not sufficiently large to motivate an organized consumer opposition.

The distribution of costs (weakly on each consumer) and benefits (strongly on each physician) results in unbalanced lobbying efforts and, therefore, regulatory outcomes that are likely to favor physicians. The costs to consumers as a group are actually larger than the gains to physicians from restrictive regulation. In effect, consumers not only pay more for physicians' services (a simple transfer from consumers to physicians), but also lose the services of those professionals excluded from practice with these restrictions.

Licensure can be justified only if there are countervailing gains associated with licensing physicians, such as quality assurance.

Institutional Design

Terry Moe has stressed the importance of rules and organizational structure to agency or board actions in two articles (1984, 1987). More specifically, in their 1987 article, McCubbins, Noll, and Weingast suggest that legislators set up agencies to produce policies that benefit their voting constituencies and minimize the necessary level of direct monitoring. In fact, they argue that the apparent lack of board oversight reflects constituent interest groups' ability to exert their institutionally granted influence over boards' actions. The outcome pleases these groups and legislators. For example, with respect to medical licensure, legislators may choose to establish medical boards that give physicians a strong influence over policy. An example is giving state medical societies the sole right to nominate medical board members.

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Researchers have identified organizational structures and rules that influence policy outcomes: legislative control over agency budgets, administrative centralization, board composition, appointment vs. election of board members, and the length of board member term.

Empirical research in this area is difficult, as there must be substantial variation in institutional arrangements and policy outcomes across states to allow an examination of the relationship. For this reason, we rely on research from historical time periods and even from non-health agencies to patch together a picture of the influence of institutional arrangements over agency policy.

Budgetary Control

Budgetary control is thought to allow legislatures greater influence over agency actions. In their 1983 paper, Weingast and Moran focused on the role of the budget in influencing the behavior of the Federal Trade Commission. The role of the budget in influencing the behavior of the Securities and Exchange Commission was investigated in a 1984 paper by Weingast and Moran; and Toma looked at the effect of budgetary allocations on the behavior of the Supreme Court (reported in her 1991 paper). In each case, these researchers found evidence that the budget is used as a control device to reward or punish agency actions.

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With respect to medical boards, funding arrangements define the level of board independence from legislative oversight. In a forthcoming article, Svorny and Toma argue that where state medical boards are funded by legislative appropriation, the legislature is more likely to pay attention to what the board is doing. For every dollar spent on medical licensure and discipline, one less dollar is available for some other board or program, giving legislators an incentive to monitor boards. If unhappy with the outcome, the legislature can use its power of the purse to punish the board. Because of the broad array of

interests legislators represent, many groups have a voice in the amount of money state medical boards receive.

In contrast, when boards are self-funded, fewer interest groups are involved in the funding process. The physicians' lobby will face less opposition in promoting its own agenda to medical board members. All else constant, financially autonomous boards are more likely to regulate in a manner consistent with physician interests. But when boards are funded through the legislature, the increased oversight makes it harder for physician lobbies to affect medical board policies.

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In 1995, of the Federation's 68 member boards—approximately 40%—operated independent of legislative budgetary control, financing their activities through fees and other revenues. Almost all of the remaining boards received a budgetary appropriation from the state legislature.

As it is in physicians' interests to restrict competition by limiting the number of licenses issued, it may be that a relationship exists between agency autonomy and the number of physicians (per capita) in a state. If autonomously funded agencies are more open to influence by physician lobbyists, then a negative relationship would be expected.[a] A test of this (using data from 1990) is in a forthcoming study by Svorny and Toma (in press). This test is hindered by the fact that, in any given year, board actions affect the flow of new physicians and have only a small effect on the aggregate stock. Nevertheless, controlling for other factors which affect the per capita measure of physicians across states, they find that physician interests appear to prevail in states where boards are free of legislative budgetary oversight. Legislative budgetary oversight appears to be associated with higher levels of physicians per capita across the United States.

If funding autonomy makes it easier for special interest groups to push policy in directions they favor, these groups would be expected to promote the establishment of autonomously funded boards. In empirical tests using present-day data on interest group size, the physician lobby (state medical society membership as a percent of total physicians in the state) does not appear to be an important determinant of whether a state board is autonomously funded. There is evidence, however, that where state legislatures meet full-time, boards are less likely to be autonomously funded. Also, where a relatively large proportion of a state's population is comprised of seniors (more than 65 years of age), boards are more likely to be autonomous.

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In their 1990 study, Graddy and Nichol include budgetary control as one of several variables used to explain variations in disciplinary actions. The basis for including budgetary control as an explanatory variable is that legislative oversight will encourage the board to spend more on discipline than the board would choose to spend on its own. Consistent with this idea, Graddy and Nichol find that when nursing boards are self-supported, fewer disciplinary actions are taken. They do not find this relationship for physicians.

Board Composition

For many, the composition of the state board is an important institutional factor. Some argue that boards comprised primarily or solely of physicians will lean toward physicians' interests. For this reason, most states mandate the inclusion of public members (non-physicians) on their medical boards. Although the number of public members on state boards is generally small, and in no case is a majority as of 1995, only seven boards had no public members.

Graddy and Nichol (1990) argue that anyone, "even naive representatives," will be stronger consumer advocates than representatives of the regulated profession. Cohen (1980) proposes that no "self-interested" individuals sit on boards. In contrast, the economic theory of government decision-making suggests that, to some extent, it doesn't matter who is on the board. The lobbying efforts of the various constituencies influence anyone who serves on a board. The idea is that, once on the board, members' incentives change. Personal gain to a physician member from policies related to physician practice is generally small compared to the potential benefits lobbying groups offer. The benefits offered by lobbyists may include opportunities for post-board employment. Although it does not focus on health care, a 1990 study by Spiller finds evidence of post-board employment in other areas.

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Additionally, since non-physician members are in the minority on state medical boards, we may not be able to assess how these boards would behave if public members had more power. In the minority, their power is limited to their ability to sway physician members to their view, if those views differ.

Using data from 1984, when there was still quite a bit of cross-state variation in entry restrictions, Graddy and Nichol (1989) examine whether the inclusion of public members on medical boards led boards to consider three specific reforms: the weakening of endorsement policies, the adoption of continuing medical education requirements, and the elimination of age, citizenship, moral conduct, and residency restrictions for licensure. The premise is that medical professionals, interested in improving their economic position in a state, would oppose all three. Graddy and Nichol, however, find no evidence that public membership on physician licensing boards had any impact on the adoption of these reforms. In contrast, when Graddy and Nichol examined other professions—registered nurses, licensed practical nurses, and chiropractors—they found that public members did reduce the incidence of "irrelevant" entry restrictions.

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In a separate paper, published in 1990, Graddy and Nichol examine whether public members influence the disciplinary performance of occupational licensing boards. They expect to find that public membership increases consumer orientation of boards, increasing the number of disciplinary actions. They find no statistical relationship between public members and aggregate disciplinary actions, but a significant positive effect of public members on serious disciplinary actions. This suggests that having public members may influence the seriousness of disciplinary action rather than the total amount of disciplinary actions.

Schultz (1983) examines California data before and after state legislation requiring public members on occupational licensing boards. He finds no evidence that public members influence board actions. Finally, a 1987 study by Schneider of Missouri's professional licensing boards finds no effect of public membership on boards. This study, however, was confined to a very small sample.

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Administrative Centralization

Administrative centralization has been suggested as a means to resolve the concern that small, independent agencies are subject to the influence of special interests. In 1995, 49 state boards reported their status as independent (FSMB).

Graddy and Nichol argue that administrative centralization benefits consumers for a number of reasons. First, it requires special interests to compete with one another for the attention of agency management, limiting the power of any particular special interest group. Also, administrative centralization may result in scale economies that reduce per unit costs as agencies increase in size. Advocates of centralization argue that larger entities allow greater job specialization, which improves efficiency and the decision-making process. And, as part of a larger organization, individual boards receive more scrutiny from the media, legislature, and consumer groups; administrative centralization should produce a more consumer-oriented board.

This conclusion seems premature as there are clearly disadvantages of administrative centralization. Most specifically, there may be diseconomies of scale—higher per service costs of running a large agency. Accountability and incentives diminish as agencies increase in size. The disadvantages of administrative centralization may outweigh the advantages.

Graddy and Nichol's 1990 paper examines the effect of centralizing the functions of individual licensing boards. They find that the centralization of administrative functions, hypothesized to improve consumer-oriented performance, has the opposite effect—administrative centralization appears to have reduced state disciplinary actions against physicians and nurses.

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Length of Term

Length of term for board members is thought to influence outcomes because longer terms insulate board members, to some extent, from repercussions of their actions. Work by Amacher and Boyes (1978) suggests that, as terms lengthen, members are less responsive to voter desires. Longer terms allow lobbyists to develop better relationships with board members, facilitating the influence of special interests. According to the Federation's 1995 *Exchange*, state medical board member term length varies from two to eight years in the United States and its territories.

Amacher and Boyes analyzed data on the behavior of United States senators over the electoral cycle. They conclude that, as the electoral period increases, officials behave in a less representative fashion. Another study, by Toma (1983), examines state boards of education. Toma finds that as term lengths increase, so does per-pupil spending. She hypothesizes that this reflects the increased influence of educator lobbies over state board members as their term length increases.

Term Limits

Term limits are used increasingly in many states to encourage representative turnover and reduce the influence of special interests over politicians. Although no researchers have looked at the effect of term limits in agencies, there is a recent study of the effect of term limits for United States governors. In work published in 1995, Besley and Case find changes in the behavior of limited-term governors consistent with an increasing concern on their part over future job prospects. As recently instituted term limits age, we can expect more research in this area.

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This research will be relevant to setting term length for members of state medical boards. In 1995, 26 boards had no term limits, the remainder limited the number of consecutive terms medical board members may serve from one to three terms.[b]

Appointed or Elected?

In South Carolina, board members are elected rather than appointed. Six members are elected from Congressional Districts, two members are elected at large, and two members are Governor appointed. It has been argued that the public has greater influence over regulatory policy when board members are elected rather than appointed. The basic idea is that the campaign process gets information to the voters cheaply and lowers the cost of acting on that information (just a vote is required).

Toma (1983) finds lower private/public enrollment ratios when education board members are elected, suggesting elected boards do a better job of meeting the needs of consumers in their states. Also, where boards are elected, she finds higher teacher workloads, lower salaries, and fewer administrative positions per pupil. Toma suggests that powerful teacher lobbies are limited in their ability to influence workloads when boards are elected rather than appointed.

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Conclusion

The studies described here provide some support for the premise that institutional arrangements influence the behavior of public agencies and boards, including state medical boards. Such empirical research is part of a growing body of work focused on explaining the behavior of government officials, politicians, and agencies. Understanding the motivations of these groups can encourage lobbying or voting for institutional arrangements that improve the match between public provision of services and what is desirable for society.

Notes

a. Although the diversity in licensing requirements across states appears to have diminished, a variety of exclusionary rules remain. According to Section 1 of the *Exchange*, state rules for eligibility to sit for the USMLE establish criteria that could limit entry. Also, states differ in retake policies and the time allowed for successful completion of the exams. In addition, there are variations in enforcement and implementation of rules that may be even more important in defining the extent to which initial entry is restricted.

b. In some states, high rates of medical board turnover make term limits less of a constraint. It would be interesting to test the relationship between medical board turnover and board autonomy. We'd expect turnover to be greatest where boards are the least autonomous (that is, have the least power over outcomes).

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