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ABSTRACT

Fiscal and policy implications of continuing education requirements in the health professions are considered, with particular reference to the case of California. For 14 professions, data are presented on the average number of hours of continuing education needed annually to meet the requirement, the costs to the practitioner, and the total annual cost in fees for each health science discipline. It is claimed that mandatory continuing education costs the state virtually nothing, either to deliver or to enforce through licensing agencies. Information is presented on the status of required continuing education among the 50 states and the District of Columbia for 16 professions, 9 in the health sciences, 2 in the social sciences, and 5 in nonhealth fields. Apparently, no 2 states agree on which of the 16 fields need continuing education requirements. It is concluded that: (1) government should encourage licensed health professionals to keep up systematically with developments in their fields; (2) for self-employed practitioners such as physicians and optometrists, continuing education tends to concentrate on developing greater depth or specialization, but for salaried practitioners such as nurses and pharmacists, it may concentrate on the development of breadth and flexibility; (3) neither the statutes nor implementing regulations for continuing education indicate what is expected of the professional learner; (4) no way exists to determine whether these educational activities are achieving any useful purpose; and (5) access to continuing education varies greatly depending on location and profession. It is suggested that these requirements place burdens on geographically isolated and low-income practitioners, are costly to both professionals and consumers, and cannot ensure professional competence. (SW)

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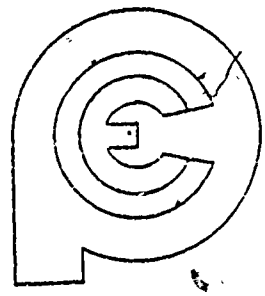
FISCAL AND POLICY IMPLICATIONS OF MANDATORY CONTINUING EDUCATION IN THE HEALTH PROFESSIONS



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A Report to the Continuing Education Committee
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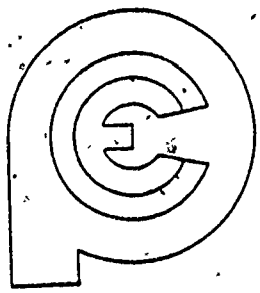

CALIFORNIA POSTSECONDARY EDUCATION COMMISSION
1020 Twelfth Street, Sacramento, California 95814

Commission Report 82-27

September 1982

CONTENTS

FISCAL AND POLICY IMPLICATIONS OF MANDATORY CONTINUING EDUCATION IN THE HEALTH PROFESSIONS

This report is the second and final document produced by the staff of the California Postsecondary Education Commission on the subject of mandatory continuing education in the health sciences. The first report, Mandatory Continuing Education in the Health Professions, dealt with the basis in law and regulation for the continuing education requirements in those health professions for which the California Legislature has either mandated or authorized licensing boards to establish educational prerequisites to relicensure. This current report examines fiscal implications--for the licensee, for State government, and for the consumer--of having continuing education requirements in the health professions. It also considers the relationship of these fiscal matters to public policy in this area.

Like the first report, this report has been prepared under a contract with the Continuing Education Committee of the Statewide Area Health Education Center System. The study leading to the report was funded at least in part by Cooperative Agreement No. DHHS U01-PE-00053-03 between the System and the Division of Medicine, Bureau of Health Professions, Health Resources Administration, United States Department of Health and Human Services.

The initial report examined the provisions of the Business and Professions Code of the State of California which require or authorize continuing education in various health professions, and the provisions of Title 16 of the California Administrative Code which represent the regulations developed by the several licensing bodies to implement the requirements for continuing education. In that report, Commission staff concluded that: (1) continuing education is not always as mandatory as one might expect, in that three boards which have been authorized to administer requirements for professions under their jurisdiction have not chosen to implement any requirement; (2) no clear-cut rationale or unifying concept of continuing education is evident throughout the requirements which do exist; and (3) no clear expectation of public benefit from mandatory continuing education seems to exist in statute or in regulations developed by the various boards. In other words, the purpose of mandatory continuing education is rather unclear.

However, in exploring the fiscal implications of mandatory continuing education in the present report, it is necessary to assume that such education serves a useful social purpose--presumably in protecting the public from health professionals whose knowledge and skills have not kept up with current practice. It is easier to make cost-benefit comparisons when one of the variables is held

constant. Assuming the social benefits of mandatory continuing education will permit us to make such comparisons, after which the assumption can be reexamined.

FISCAL IMPLICATIONS FOR THE LICENSEE

It is necessary first to examine the costs of mandatory continuing education to those health professionals who must acquire a specified number of hours of such education before being relicensed. Professionals in this category are the following: chiropractor, dentist, hearing aid dispenser, licensed vocational nurse, nurse (including nurse practitioner, public health nurse, nurse anesthetist, and nurse midwife), nursing home administrator, osteopath, pharmacist, physician, podiatrist, registered dental assistant, and registered dental hygienist. Practitioners in these fields are required to take an average of from 6 to 50 hours of continuing education annually, and, except in circumstances to be noted shortly, to pay for such education themselves.

No direct State support goes to either the practitioners who take continuing education courses, or to the providers who present them. Expenses for such education are generally tax-deductible, of course, but nevertheless distinct out-of-pocket costs are normally associated with meeting continuing education requirements. Some practitioners in the list above do not have high salaries or professional compensation; for such practitioners, continuing education can be a financial hardship. Even for those professionals whose compensation may be substantially higher, e. g., physicians and dentists, participation in continuing education may represent considerable financial sacrifice, in that high fees may be required for the education at the same time that income may be lost in not seeing patients while the overhead costs of the practice continue. The cost of the education may be partially offset by tax deductions, but the lost income produces no corresponding tax offset--unless losing money is considered the ultimate tax shelter.

A quick set of hypothetical but not unrealistic examples serves to illustrate the point. A nurse making $18,000 a year might have to spend $60 for a one-day continuing education course that could meet perhaps one-third of her annual continuing education requirement. If she had to give up a day of work to take this course, her out-of-pocket costs would more than double. (Because of the burden that continuing education represents in both money and time, many hospitals are offering free continuing education on the premises to nurses as a recruiting and retention incentive; but as will be noted later, this practice ultimately adds to the cost of patient

care in the hospital.) By the same token, a physician making $70,000 a year might spend $250 for a one-day continuing education course that could meet perhaps one-fifth of his annual continuing education requirement. But he might also have to forego patient income of $500 or $600 for the day while his office operating expense of $200 or $300 a day continued. In both cases--nurse and physician--continuing education has a very real price tag.

The costs of participation are greatest, of course, when the practitioners are in relatively isolated geographical areas, too lightly populated to support continuing education activities locally. In this case, health professionals have to travel significant distances to participate in continuing education. Again, travel costs may be tax deductible, but foregone income is not. It is interesting to note that the staff of the California Postsecondary Education Commission in preparing the first report in this series questioned the staffs of the licensing boards about how the needs of practitioners in geographically isolated areas were taken into consideration by the boards in developing specific procedures to implement the continuing education requirement. No board staff indicated that any special efforts were made to accommodate the needs of isolated practitioners other than through limited use of correspondence courses or perhaps videotape; several staffs even indicated that they found that practitioners actually prefer the "day in the city" approach, in contrast to meeting the requirement locally, since it provides opportunities for professional and social contact for the practitioners as well as shopping and entertainment opportunities for spouses. While this approach may indeed fit the traditionally more mobile professionals such as physicians and dentists, there is some question as to whether nurses, LVNs, drug store pharmacists, registered dental assistants, and nursing home administrators can afford to be that mobile if based in such places as Alturas, Crescent City, Atascadero, Bishop, Needles, or Blythe.

Considering the impossibility of delivering continuing education at a profit or even breaking even in some remote areas as well as the difficulty of practitioners finding the time and money to get to the closest continuing education opportunities, it is remarkable that the mandatory continuing education requirement works at all. Certainly the decentralization of graduate medical education--as stimulated by both the State's Song-Brown Act and by the federally funded Statewide Area Health Education Center System of the University of California, San Francisco--has been a key to making such locations as Fresno, Redding, Salinas, Stockton, Bakersfield, Ventura, and San Bernardino into centers where continuing education in medicine is available to large rural service areas. But in a number of the fields identified above as being particularly vulnerable to isolation, these mid-size communities generally do not have any special educational resources which can be utilized to regional-

ize the delivery of continuing education in those fields. Even in nursing, which is the only primarily hospital-based health profession with a continuing education requirement, the existence of hospitals even in communities as small as several hundred people is no assurance that a base exists for a continuing education program, since--even if there were enough nurses in the immediate vicinity to make a program financially viable--only very limited educational resources exist in many of these isolated communities.

To reiterate, it is indeed remarkable that continuing education requirements are being met by health professionals in isolated areas. The price for this accomplishment may be considerable personal sacrifice in time and money beyond that expected of practitioners in urban areas. But even urban practitioners, while saving on travel costs, still face the basic registration fees for continuing education courses, fees that are not insignificant.

Before summarizing the level of these fees, it may be helpful to note how continuing education in the health sciences is marketed. Usually someone in an organization which is a provider of continuing education, such as an educational institution, an association, or entrepreneurial group, recognizes through an assessment of the market an opportunity for a profitable continuing education course. From a business management perspective, the fee for the course is established to maximize profit--"whatever the market will bear." There are limitations to fees, however, including those of any marketplace--among them, the availability of competition, and the ability of the user to pay. Also, the sponsoring organization may be a nonprofit organization, in which case it may set the fee low enough to recoup only costs.

The staff of the California Postsecondary Education Commission has reviewed a number of continuing education brochures and has consulted with health professionals in an effort to determine the range of fees for the continuing education courses currently available to health professionals in this State. From these ranges of fees, a "representative" per-hour fee level has been selected for each field for comparative purposes. This representative level is only that, rather than a mode or mean or median; it is a fee level that could and does exist in some courses without approaching the upper or lower limits of fees. In Table 1, the number of licensed practitioners is shown for each health field which has a continuing education requirement or authorization, together with the average number of hours of continuing education needed annually to meet the requirement, the "representative" cost per hour in fees, the annual cost per practitioner, and the total annual cost in fees for each health science discipline.

TABLE 1

COST OF CONTINUING EDUCATION COURSES IN HEALTH SCIENCES

Profession	Approximate Number Licensed 1981-82	Average Number of Continuing Education Hours Required Annually	Representative Cost per Hour of Continuing Education	Annual Cost of Continuing Education to Licensee	Annual Cost of Continuing Education to Health Profession
Acupuncturist	1,500	0	--	--	--
Animal Health Technician	2,000	0	--	--	--
Chiropractor	5,800	12	$10	$120	$ 696,000
Dentist	25,500	25	12	300	7,650,000
Hearing Aid Dispenser	880	6	7	42	36,960
Licensed Vocational Nurse	67,250	15	7	105	7,061,250
Nurse	198,100	15	8	120	23,772,000
Nursing Home Administrator	2,900	20	10	200	580,000
Optometrist	8,000	0	--	--	--
Osteopath	1,250	50	12	600	750,000
Pharmacist	27,000	15	10	150	4,050,000
Physician	82,000	25	12	300	24,600,000
Podiatrist	2,000	25	10	250	500,000
Registered Dental Assistant and Registered Dental Hygienist	20,150	12.5	4	50	1,007,500
TOTAL, SUBJECT TO MANDATORY CONTINUING EDUCATION	432,830				$60,703,710

Source of Number of Licensees: 1982-83 Governor's Budget. Dental auxiliaries are combined into a single category in this source. It should also be noted that in many fields a large number of the licensees are not physically located in California, even though they maintain California licenses.

Obviously, Table 1 only approximates what average fees for continuing education may be to the health professional. Nevertheless, it is reasonable, using the representative per hour costs of continuing education credit listed in the table, to assume that the cost of continuing education courses to health professionals or their employers may be in the order of $60 million annually. This total does not include any additional expenses associated with taking such courses--only the course registration fees.

To provide some perspective or comparability on the size of this outlay, one can compare it to student fees in higher education. According to the 1982-83 Governor's Budget, in the University of California in 1981-82 the two major fees paid by students each produced an amount roughly comparable to this continuing education outlay, with the education fee producing $64 million and the registration fee producing $58 million. Similarly in the California State University, student fees produced $68 million. The level of these charges to students is generally a matter of some awareness and concern by the Legislature, but the level of outlay for State-mandated continuing education for health professionals appears to be of no interest to legislators. This lack of interest may reflect the fact that the users of continuing education are gainfully employed as a benefit of their licenses, or it may be because the fees are not used as offsets to State budgets. In any event, the legislators who imposed the continuing education requirements might be well advised to review from time to time the costs that they have imposed upon licensed professionals, particularly with respect to the public benefits that the legislators expect to achieve with mandatory continuing education.

FISCAL IMPLICATIONS FOR THE STATE

Mandatory continuing education costs the State virtually nothing, either to deliver or to enforce through licensing agencies which derive their revenue from fees. Neither of the two major delivery systems that supply continuing education in the health fields receives General Fund support for this specific purpose. The private system consists of professional associations, corporations (both profit and nonprofit), and private entrepreneurs. The public system consists primarily of public institutions of higher education but also includes public hospitals.

The largest public provider of continuing education in the health sciences in California is the University of California through its five schools of medicine, two schools of dentistry, two schools of nursing, one school of pharmacy, one school of optometry, one

school of veterinary medicine, and an affiliated school of podiatry. As a general policy, all continuing education or extension programs sponsored by the University pay their own way, and no General Fund or Regents' funds are used for their support, although as will soon be apparent, there are departures from this policy. No law or Master Plan provision precludes the use of State support for this purpose, however, and through most of the 1960s, University Extension did receive significant amounts of State support. Even today certain elements of office overhead for University Extension such as utilities are absorbed in campus General Fund budgets.

Without State support of programs, continuing education in the health sciences for all practical purposes is driven by the possibility of making a "profit" on the courses offered. This situation has brought a number of levels of the University into continuing education, sometimes in competition with each other. On the UC health sciences campuses, this might mean that continuing education programs are offered at the institutional level by University Extension, at the college level by the medical or nursing school, and even at the departmental or divisional level by a department of otolaryngology or by an institute of neuropsychiatry.

This competition is not necessarily undesirable, but it does produce two negative effects. First, the identification and serving of needs tends to concentrate on the "profitable" markets, with the result that the larger view of continuing education's responsibility to serve marginal or unprofitable markets with revenues derived from solid bread-and-butter programs often gets overlooked. Second, the disposition of the revenues becomes unclear, particularly with respect to their use for salaries. At each campus level, University staff members spend time administering continuing education, yet their salaries are paid by General Fund sources--apparently in disregard of the general intent of the Legislature. In the most recent round of budget cuts within the University, several continuing education staff positions appear to have been cut, and the staff reassigned. This circumstance strongly suggests that General Fund money has been going to the support of positions that were used in continuing education, at the same time that substantial revenues were being derived from continuing education courses.

At the level of University Extension, there are established policies and procedures for dispensing the "profits" of continuing education, but the same situation does not exist at all college or departmental levels. The awkwardness of this situation is compounded by the development of foundations to handle continuing education and its revenues at these other levels of the campus; foundations are notoriously difficult to monitor, and their growth may necessitate some overview by the Legislature. An ambivalent situation exists with respect to foundations, in that the Legislature wants to

encourage educational programs to be creative in finding external sources of funding to reduce dependence on the General Fund, but is reluctant to encourage the development of shadow funds, the disposition of which is not subject to legislative review.

In the California State University, the situation is somewhat different, primarily because of much less extensive development in most health sciences education fields. Nursing, however, is a major program within CSU, and continuing education programs exist in this field. Some General Fund money has been spent on partial support of the continuing education dean's office at the campus level, but this money appears to have been eliminated from the upcoming budget. Institutional foundations have been used on a number of campuses, but on occasion have acquired a reputation for becoming involved in inappropriate activities.

With this background established, it is now useful to explore existing policies, and to ask why professionals facing mandated continuing education should be expected to pay the full cost of that education. Mandated continuing education in health and other professions represents the only compulsory postsecondary education in California. All other postsecondary education is voluntary, and in virtually all other public postsecondary education there is State subsidy to some degree. For example, in the course of educating physicians, the students receiving basic undergraduate education in public institutions may contribute only a quarter of the cost of that education. Medical education is similarly priced--at least for the present. Graduate medical education or residency training is free, and carries a stipend. But postgraduate or continuing medical education which is mandated more fully by law than all but the first year of graduate medical education must be paid for in full by the learner, with the State offering no subsidy.

In its 1981 report, Linking Californians for Learning, the California Postsecondary Education Commission observed that (p. 63):

> Viewing continuing professional education as a major public need does not imply any judgment that the State should pay for it. Ensuring that a need can be met may be distinguished from paying for it.

This statement may appear to suggest that this agency has concluded that the State does not have any responsibility to share in the cost of continuing education that it mandates. However, it is more accurate to interpret the statement as noting that it does not necessarily follow that the existence of the need (and thus the mandate) automatically means that the State should pay the costs of meeting the need. Instead, if the State were to share in the costs, then the reasons for doing so should be established exter-

nally, and not derived internally from the mere existence of the need. This is not necessarily to argue that the State should pick up part of the cost of mandatory continuing education, but it is to suggest that some external factors should be considered, particularly the practice of requiring, without any State assistance, a class of citizens to spend its own money on the full costs of education which it must have periodically in pursuit of the right to work in a chosen field, while other citizens of the State participate in education voluntarily and, for the most part, pay only a portion of the costs of the education.

Perhaps the most significant part of the earlier Commission observation is its second sentence, not its first. It infers that ensuring the need is met may be the State's responsibility, even if paying the cost of meeting the need may not be. Again it may seem like semantic hairsplitting to explore the difference in these two concepts, but a difference does exist. Ensuring that the need can be met may mean such things as the removal of fundamental barriers which prevent continuing education from succeeding, irrespective of who is paying for it. As such, it may indeed be the kind of activity in which the State should be more fully involved--even if it carries a price tag of its own. In this sense, the absence of a flexible and coordinated continuing education delivery system in California, made up of learning centers and electronic resources, does retard the adequate development of continuing education in the health professions--along with other forms of postsecondary education--in areas some distance from major centers of education. If the State were to assume responsibility for development of the physical foundation--the hardware--of such a learning network, then certain tangible barriers to educational development could be eliminated. The State as a facilitator would ensure that the need can be met, and the user could continue to pay for the programmatic aspects of his or her education.

In the present fiscal climate, the possibility of the State supporting such a learning network is indeed remote. There may be other moments, however, when the State can again address the problems of physical and geographical access to postsecondary education. It seems reasonable to expect that mandated continuing education should receive some attention at that time in determining what State resources should be devoted to various needs. Or, alternatively, there may come a time when the State will reconsider the efficacy and even the wisdom of the continuing education requirement for health personnel.

FISCAL IMPLICATIONS FOR THE HEALTH CARE CONSUMER

One might readily assume that if continuing education is functioning properly, health care can be delivered more cost effectively and theoretically more inexpensively to consumers because of the additional training that health professionals receive. From this perspective, the most questionable kind of continuing education by today's standards--that identified as "practice management"--may have the most direct benefit to consumers. For example, those professionals who operate office practices, such as physicians, dentists, osteopaths, podiatrists, and chiropractors, could run their practices more cost effectively and thereby pass on to consumers at least part of their savings if they participate in continuing education oriented toward practice management. Other practitioners who are already more involved in marketing, such as pharmacists, nursing home administrators, and hearing aid dispensers, are probably now participating in continuing education which has the potential for reducing costs for consumers. From this orientation, mandatory continuing education in the health professions appears justified less because of public safety than because of economic consumer protection--as with mandatory continuing education of real estate personnel and accountants. (The next section of this report notes how various states approach mandatory continuing education in a number of fields, including those in which the consumer's interests are more purely economic than in the health professions.)

It is quite possible, however, to develop an antithetical point of view which is also reasonable. It holds that State-mandated continuing education of health professionals increases costs for consumers of health care because of the fact that continuing education represents a cost to health professions and, following the time-honored premise of economics that "one man's price is another man's cost," the price of continuing education is ultimately reflected in the cost of health care. Under this view of the health care marketplace, the costs of continuing education appear to add to the total costs of health care, although by an amount which cannot be determined accurately.

Examples of this high-cost assumption are more common than those of the reduced-cost point of view. Thus the 1979 California State Health Plan, drawing on the report of the Governor's Special Committee on Health Care Costs, argues that the credentialing of health care personnel--obviously including required continuing education for relicensure--needs reform in order to reduce the costs of health care. It makes no estimate of potential cost savings, but it recommends that "the benefits of existing health facility and personnel licensure and certification regulations should be evalu-

ated, the benefits of future regulations demonstrated, and redundant and duplication regulations eliminated" (p. 28).

The Report of the Governor's Special Committee on Health Care Costs is equally general on the matter of the relationship of credentialing requirements to the cost of health care, although it does specifically refer to education as part of these requirements:

> Unnecessary requirements in the standards for training required for credentials contribute to the total unnecessary cost of health care. The complex and uncoordinated structure itself, even though it is maintained principally through licentiate fees, nevertheless contributes to the overall health care costs (1979, p. 24).

Unfortunately, neither the State Health Plan nor the Report of the Governor's Special Committee on Health Care Costs discuss specifically the costs of health care that are supposedly added by mandatory continuing education. Some measure of these costs can be inferred, however, from a statement by Leonard Fenninger, vice president for medical education of the American Medical Association, in a 1980 book by Keith Alan Lasko, M. D., with the interesting title of The Great Billion Dollar Swindle, to the effect that "continuing medical education now costs about $4 billion a year--including $750 million for courses, study material, and travel" (p. 212). If California is responsible for 10 percent of this total, some $75 million may be spent annually out-of-pocket by California physicians on courses and travel--an amount roughly comparable to the earlier estimate in this paper of about $25 million for courses alone, apart from travel costs. That leaves $325 million of the estimated $400 million as California's share of the rest of the cost of continuing medical education. This amount appears to be largely the residual cost to physicians of maintaining offices together with the loss of patient revenue during continuing education sessions. Regardless of whether the costs are out-of-pocket or residual, California physicians would seem justified in figuring in the costs of continuing education--all $400 million--in pricing their services.

Some critics of mandatory continuing education such as Fenninger and Lasko argue that it does not make effective use of physician time nor provide the best means of insuring physician competence. To assure competence, some of these critics are calling for periodic relicensure through reexamination. Yet even if they are eventually successful in eliminating mandatory requirements for continuing education, some of these costs would remain because most physicians would continue to pursue voluntary continuing education.

PUBLIC POLICY IMPLICATIONS OF MANDATORY CONTINUING EDUCATION

As an introduction to a review of the implications for public policy which derive from the fiscal dimensions of mandatory continuing education, Table 2 shows the status of required continuing education among the 50 states and the District of Columbia in 16 different professions: nine in the health sciences (dentists, licensed practical [vocational] nurses, nurses, nursing-home administrators, optometrists, pharmacists, physical therapists, physicians, and veterinarians), two in the social sciences (psychologists and social workers), and five in other fields (architects, certified public accountants, engineers, lawyers, and real estate personnel). The symbols indicate whether continuing education is (1) required by statute or regulation, (2) required under certain circumstances, (3) permissive under enabling legislation, and (4) required under certain circumstances and by statute or regulation. Blank spaces indicate no requirements.

Several things are immediately apparent from this table:

- First, states vary enormously in their disposition toward requiring continuing education, ranging from Iowa with 15 professions affected and Kansas and New Mexico with 13 each, to Connecticut, Missouri, New York, and the District of Columbia with only two professions subject to continuing education requirements.

- Second, enormous variation also exists as to the extent of regulations among the professions. Optometrists have some form of regulation in 46 of the 51 jurisdictions, while nursing home administrators are regulated in 43 and certified public accountants in 38. (In each of these cases, the rationale for the requirements may be different, with optometrists possibly regulated through the actions of the profession itself in order to attain recognition and comparability with physicians, nursing home administrators regulated out of humanitarian concerns for the welfare of elderly patients, and CPAs regulated for economic concerns.) The least universally regulated professionals of the 16 on this table are physical therapists in only three jurisdictions and engineers in four.

- Third, apparently no two states agree on which of the 16 fields need continuing education requirements. The median number of the 16 fields regulated is six; the mode is four and seven. California regulates more than most with ten; only five states regulate more than ten.

TABLE 2. STATE REQUIREMENTS FOR CONTINUING EDUCATION IN 16 PROFESSIONS

	Architects	Certified public accountants	Dentists	Engineers	Lawyers	Licensed practical nurses	Nursing-home administrators	Nurses	Optometrists	Psychologists	Pharmacists	Physical therapists	Physicians	Real estate personnel	Social workers	Veterinarians
Alabama			•			•			•	•		•			•	•
Alaska			•					■	•	•	♦	♦		•		
Arizona	♦		♦			■			•	•	•	•		•	•	•
Arkansas			•						•	•	♦	•		♦	•	•
California			•	•		■	•	•	•		•	•		•	•	
Colorado			•			•	•	♦			•			•		•	•
Connecticut			•							•						
Delaware									•	•						•
Dist. of Col			•									♦				
Florida	♦		•			■	•	•	•	•		•			•	•
Georgia			•			■			•	•	•				•	
Hawaii			•						•	•				•		
Idaho						•			•	•		•				
Illinois										•				•		•
Indiana			•						♦	•		•				•
Iowa	•		•	•	•	○	•	•	•	•	•	•	•	•	•	•
Kansas			•	•			•	•	•	•	♦	•	•	•	•	•
Kentucky				•			•	•	•	•		•		♦	•	•
Louisiana			•					♦	•	•	•	•			•	
Maine			•						•	•		•		•	•	
Maryland			•						•	•	•			•	•	•
Massachusetts			•	•			•	•	•	•				•	•	
Michigan			•				•	♦	•	•	♦	•		•		
Minnesota	♦		•	•	♦	•		•	•	•	♦	•		•	•	
Mississippi								■	•	•		•				
Missouri									•	•						
Montana			•		•				•	•		•				•
Nebraska			•				•	•	•	•				•		•
Nevada			•				•	•	•	•		•		♦	•	♦
New Hampshire	♦							■	•	•		♦		•		•
New Jersey	♦			■					•	•		•				
New Mexico	♦		•	•		■	•	•	•	•	•	•	•	•		•
New York									•						•	
North Carolina			•		♦				•	•	♦					•
North Dakota			•	•		•			•	•					•	
Ohio			•						•	•		•		•	•	•
Oklahoma			•						•	•		•		•	•	
Oregon			•	•				■	•	•	•	•			•	•
Pennsylvania			•						•	•				■		•
Rhode Island			•							•				•		
South Carolina			•					○	•	•						
South Dakota			•	•				•	•	•		•			•	•
Tennessee			•							•					•	•
Texas			♦			■			•	•	•				•	
Utah										•	•			•	•	•
Vermont			•						•	•	♦					
Virginia							•			•					•	
Washington			•			•		♦	•	•	•	•		•	•	•
West Virginia									•	•	•					
Wisconsin						•			•					•	•	
Wyoming			•			•			•	•	♦	♦				

SOURCE: LOUIS E. PHILLIPS, UNIVERSITY OF GEORGIA

- • Required by statute or regulation
- ■ Required under certain circumstances.
- ♦ Enabling legislation passed.
- ○ Required under certain circumstances and by statute or regulation

Source: Watkins, 1982, p. 16, from data collected by Louis E. Phillips, associate director, Center for Continuing Education, University of Georgia.

In assessing the meaning of these differences for state policy, one may well ask: Is life any safer, more healthful, or even more economically secure, in those states that require continuing education for license renewal in a number of professions than in those states regulating only a few professions? Unless this question can be answered with some degree of affirmation, the justification for mandatory continuing education seems to evaporate.

SOME GUARDED OBSERVATIONS

So far in this report, as in its earlier report on the legal basis of mandatory continuing education, the staff of the California Postsecondary Education Commission has raised a number of questions about requirements for continuing education. Now, however, at least a few cautious conclusions are in order about the inferences that can be drawn for public policy from existing data as well as about issues that remain unresolved.

- Consensus seems widespread that all persons trained in the professions and in technology should be expected to learn more about their fields throughout their professional lives. Licensed health professionals, in particular, should be expected to keep up systematically with development in their fields because of the influence they exert on life and health and because of the rapidity of technological change in their fields. In the interest of better health of its citizenry, government should both expect and encourage health professionals to participate in worthwhile continuing education activities.

- Continuing education for health professionals probably serves different purposes and has different foci among different fields as well as among individual practitioners within each field. Thus for self-employed practitioners such as physicians, dentists, osteopaths, podiatrists, optometrists, veterinarians, and chiropractors, continued education tends to concentrate on developing greater depth or specialization. In contrast, for salaried practitioners such as nurses, LVNs, pharmacists, dental auxiliaries, nursing home administrators, and hearing aid dispensers, it may reflect more attention to the development of breadth and flexibility. Yet neither the statutes requiring continuing education nor their implementing regulations currently indicate what is expected of the professional learner, and little opportunity exists for government encouragement of individualized patterns of systematic ongoing learning.

- Under the present system of mandatory continuing education, no way exists to determine whether these educational activities are achieving any useful purpose. For example no evidence is available that, as a result of California's requirements, Californians are healthier than the residents of the 26 states and entities that do not require continuing education for physicians, the 32 states that do not require continuing education for nurses, or the 40 that do not require continuing education for dentists.

- Assuming that the maintenance and enhancement of competence in areas of professional practice are the purposes of educational requirements for relicensure, the demonstration of such competence can be achieved in other ways than by mandatory continuing education. Comparisons of these alternatives to continuing education can be helpful in examining the usefulness of current requirements.

- A large amount of money is being spent on continuing education without much awareness or interest on the part of the State. State government neither spends money nor collects money on the continuing education it mandates, but almost half a billion dollars worth of such activity annually contributes to higher costs in medical care alone. Voluntary continuing education, which many health professionals would pursue regardless of any requirement, would involve many of these same costs.

- Access to continuing education varies enormously from place to place and from profession to profession, and the State has done little to address this problem.

In summary, the State, in the interest of assuring competence among health professionals, has accrued a set of statutory requirements for continuing education unclear in intent, inconsistent in emphasis, and inequitable in the burdens they place on geographically isolated and low-income practitioners. These requirements, which carry no financial benefit nor liability for the State but which are costly to professionals and consumers alike, cannot in the end provide absolute assurance of professional competence.

In this light, it is possible--even easy--to be quite negative toward continuing education requirements, as Governor Brown has recently been in vetoing such a provision for psychiatric technicians. Recent literature on the subject of continuing education seems much more skeptical of the benefits of state-mandated educational requirements for relicensure than was the literature of the early 1970s when the impetus toward expanding such requirements was at its peak.

As educators, the staff of the Postsecondary Education Commission believes in the benefits of continuing education in the health professions, but concludes that in its present form, mandated continuing education for certain health professions does not demonstrate benefits commensurate with its social costs. For this reason, if the State had assumed any measure of the direct costs of administering continuing education during the past decade, the staff suspects that the Legislature would most likely have discontinued this support during the recent budget crisis.

At least three alternatives seem evident for State policy in the future.

The first is the status quo, or "muddle through" approach, tolerable enough since it costs the state nothing in direct support.

The second is the abandonment of requirements, inherently an attractive alternative since no social benefits are demonstrable at present from the requirements. This change could be made with or without adopting another means of assuring the competency of health professionals, but giving up all statutory means of maintaining their competency would not only be an abdication of responsibility but might be unrealistic in today's litigious society.

The third alternative would be for the State to reform present continuing education requirements to make them more realistic, meaningful, and workable in ways yet to be explored. The Legislature might wish to reexamine the appropriateness of including certain fields within the mandate for continuing education, the effectiveness of the various boards in carrying out the present requirements, the need for evaluation of continuing education as a means of assuring professional competence, or the use of other methods to assure this competence. This alternative would undoubtedly cost the State money, but so do most governmental activities done in the name of public health and welfare.

The Commission staff makes no brief for any of these alternatives. It does, however, suggest that an educational activity whose total societal costs exceed half a billion dollars each year requires more than head-in-the-sand oversight by the State.

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