

Washington International Law Journal

Volume 17 | Number 3

6-1-2008

The Need for Effective Licensure Laws for Mid-Level Health Care Providers in Countries Facing Chronic Physician Shortages: A Case Study of the Marshall Islands' Health Assistants

Jeffrey P. Lane

Follow this and additional works at: <https://digitalcommons.law.uw.edu/wilj>

 Part of the [Comparative and Foreign Law Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

Jeffrey P. Lane, Comment, *The Need for Effective Licensure Laws for Mid-Level Health Care Providers in Countries Facing Chronic Physician Shortages: A Case Study of the Marshall Islands' Health Assistants*, 17 Pac. Rim L & Pol'y J. 767 (2008).

Available at: <https://digitalcommons.law.uw.edu/wilj/vol17/iss3/8>

This Comment is brought to you for free and open access by the Law Reviews and Journals at UW Law Digital Commons. It has been accepted for inclusion in Washington International Law Journal by an authorized editor of UW Law Digital Commons. For more information, please contact cnyberg@uw.edu.

THE NEED FOR EFFECTIVE LICENSURE LAWS FOR MID-LEVEL HEALTH CARE PROVIDERS IN COUNTRIES FACING CHRONIC PHYSICIAN SHORTAGES: A CASE STUDY OF THE MARSHALL ISLANDS' HEALTH ASSISTANTS

Jeffrey P. Lane[†]

Abstract: Facing a global physician shortage and high international emigration rates, developing countries are increasingly looking to mid-level health care providers to provide critical primary health care services. Mid-level providers have more training than nurses but less than full physicians and are typically authorized to prescribe medications and perform simple medical procedures. As the demand for health care providers continues to grow, mid-level providers are increasingly being asked to provide a broader array of clinical services. In response to this growing need, mid-level providers are increasingly practicing outside of their licensed scope of practice, which may both compromise patient safety and expose providers to legal liability. To ensure that countries are striking an appropriate balance between the increasing need for health care providers and the need to protect patient safety, the World Health Organization (“WHO”) has called on countries to review their medical licensure laws to ensure that they clearly and appropriately define mid-level providers’ scope of practice, degree of autonomy, initial and continuing educational requirements, and disciplinary mechanisms.

One developing country that is utilizing mid-level providers to address its chronic physician shortage and whose licensure laws fail to satisfy the WHO recommendations is the Republic of the Marshall Islands (“Marshall Islands”). The Marshall Islands’ health assistants provide critical primary health care services to the country’s outer island communities. However, the licensure law applying to health assistants does not clearly define their scope of practice, degree of autonomy, or continuing education requirements. As international aid from the United States decreases in the coming years and the outer island health care system likely deteriorates, these health assistants will be faced with increasingly difficult treatment scenarios. To ensure that these providers are adequately trained for these situations, the Marshall Islands should enact a comprehensive health assistant licensure scheme consistent with the WHO recommendations. After analyzing existing medical licensure laws in the Marshall Islands, this Comment will propose a comprehensive health assistant licensure scheme that is consistent with WHO recommendations and modeled on the Marshall Islands’ Nursing Practice Act.

I. INTRODUCTION

On a small atoll in the Republic of the Marshall Islands (“Marshall Islands”), a mother carries her five-year-old boy with labored breathing into the local health center. After informing the mother that there is no doctor on the island, the local health assistant examines the boy and determines that

[†] Juris Doctor expected 2009, University of Washington School of Law. Masters of Public Health expected 2010, University of Washington School of Public Health and Community Medicine. The author would like to thank the editors of the *Pacific Rim Law & Policy Journal* and Dr. Patricia Kuszler for their assistance on this Comment.

swelling in his throat is obstructing his airway. Fearing that the boy's condition may worsen, he asks the boy's mother to take his boat to the next island to radio the hospital and request that a boat be sent to transport the boy to the capital. Over the next few hours, the boy's face begins to turn blue from lack of oxygen. When the mother returns after successfully contacting the hospital, she begs the health assistant to do something. During his initial training five years earlier he was trained in how to perform an emergency tracheotomy but is not certain whether he should perform one without the supervision of a physician. Ultimately, he decides to wait for the transport. When the boat finally arrives six hours later, a physician immediately performs a tracheotomy and the boy's breathing stabilizes. However, the physician fears that the boy may have suffered irreversible brain damage during the ordeal.

This hypothetical scenario in the Marshall Islands, illustrates the life and death treatment decisions that mid-level health care providers must make every day in countries facing physician shortages. A recent World Health Organization ("WHO") report concluded that there is a global shortage of more than four million health care providers.¹ This shortfall is most severe in developing countries² due to the high rates of international emigration by health care providers³ and a lack of local training capacity.⁴ In response to this medical "brain drain,"⁵ governments in developing countries are increasingly depending on mid-level providers to provide critical primary health care services—especially in rural areas.⁶ Mid-level providers include health care clinicians who have received less training than a full physician, but more than a nurse.⁷ In response to the physician shortage, mid-level providers around the world are providing an expanding array of clinical services, some of which fall outside of their legal scope of

¹ U.N. WORLD HEALTH ORGANIZATION [WHO], THE WORLD HEALTH REPORT 2006: WORKING TOGETHER FOR HEALTH 12 (2006), available at http://www.who.int/whr/2006/whr06_en.pdf.

² See *id.* at 10-12.

³ Lincoln Chen et al., *Human Resources for Health: Overcoming the Crisis*, 364 LANCET 1984, 1986 (2004).

⁴ Vasant Narasimhan et al., *Responding to the Global Human Resources Crisis*, 363 LANCET 1469, 1470 (2004).

⁵ See Brenda Wilson, *Developing Countries See Health Care 'Brain Drain'*, NAT'L PUB. RADIO, Nov. 3, 2005, <http://www.npr.org/templates/story/story.php?storyId=4987628>.

⁶ See Charles Hongoro & Barbara McPake, *How to Bridge the Gap in Human Resources for Health*, 364 LANCET 1451, 1453 (2004).

⁷ See Fitzhugh Mullan & Seble Frehywot, *Non-Physician Clinicians in 47 Sub-Saharan African Countries*, 370 LANCET 2158, 2159 (2007).

practice.⁸ These increasingly common conflicts between clinical necessity and law can endanger patient safety if the providers are not adequately trained to provide these services⁹ and expose providers to legal liability for exceeding their licensed scope of practice.¹⁰

To ensure that countries are striking an appropriate balance between the increasing need for additional health care providers and ever present need to protect patient safety, the World Health Organization (“WHO”) has called on countries to review their mid-level provider licensure laws.¹¹ To ensure adequate provider competency and protect mid-level providers from legal liability, the WHO has recommended that licensure laws clearly define mid-level providers’ scope of practice, degree of autonomy, initial and continuing educational requirements, and accountability standards.¹²

One developing country that is utilizing mid-level providers to address its chronic physician shortage¹³ but has failed to enact a licensure scheme that satisfies the WHO recommendations is the Marshall Islands.¹⁴ The Marshall Islands established a category of mid-level providers, known as health assistants, to provide primary health care services to its remote island communities.¹⁵ After completing an eighteen month training program, health assistants are stationed at remote outer island health centers and expected to provide a broad array of primary health care services.¹⁶ However, the current health assistant licensure framework fails to provide adequate guidance regarding the outer limits of health assistants’ scope of practice or degree of autonomy. In addition, the current licensure scheme does not require health assistants to undergo any continuing education

⁸ WHO, *Mid-Level and Nurse Practitioners in the Pacific: Models and Issues*, 16, 21 (2001), available at <http://www.wpro.who.int/NR/rdonlyres/2B4C3B03-7F6F-47CF-A001-06305ABEA3DD/0/nursescoverall.pdf>.

⁹ See Phyllis Coleman & Ronald Shellow, *Extending Physician’s Standard of Care to Non-Physician Prescribers: The RX for Protecting Patients*, 35 IDAHO L. REV. 37, 50 (1998) (emphasizing the importance of mid-level providers completing appropriate training programs prior to being granted prescriptive authority); see also WHO, *supra* note 8, at 16 (stating that the scope of practice for mid-level providers should be clearly defined and extend to “services . . . for which they have been trained”).

¹⁰ WHO, *supra* note 8, at 16.

¹¹ See *id.*

¹² *Id.* at 21.

¹³ Bhalachandra H. Keni, *Training Competent and Effective Primary Health Care Workers to fill a void in the outer islands health service delivery of the Marshall Islands of Micronesia*, 4 HUMAN RESOURCES FOR HEALTH 27, § 1 (2006), <http://human-resources-health.com/content/4/1/27>.

¹⁴ U.N. OFFICE OF THE HIGH REPRESENTATIVE FOR THE LEAST DEVELOPED COUNTRIES, *Landlocked Developing Countries, and Small Island Developing States - List of Small Island Developing States*, <http://www.un.org/special-rep/ohrlls/sid/list.htm> (last visited Apr. 6, 2008) [hereinafter UN-OHRLLS] (designating the Republic of the Marshall Islands as a Small Island Developing State).

¹⁵ See Keni, *supra* note 13, § 1.

¹⁶ *Id.*

courses. As illustrated by the scenario above, clear scope of practice, degree of autonomy, and continuing education regulations are critical to ensuring safe and effective medical care in areas facing chronic physician shortages.

The Marshall Islands Ministry of Health attempts to clarify the role of the health assistants by maintaining a radio communication and triage system between the health centers and the national hospital in Majuro.¹⁷ The health assistants can use this system to request treatment guidance from physicians in Majuro,¹⁸ as well as to request transfers for complicated cases.¹⁹ However, as financial assistance from the United States decreases in the coming years,²⁰ evidence of past budget reductions indicates that this radio communication and patient triage system will begin to deteriorate.²¹ Consequently, situations such as the hypothetical above may become increasingly common in the years ahead.

To ensure that health assistants are being utilized to their full potential without compromising patient safety, the Marshall Islands should enact a licensure scheme that clearly defines health assistants' scope of practice, degree of autonomy, initial and continuing education requirements, and disciplinary mechanisms.²² In drafting this law, the Marshall Islands can look to its own Nursing Practice Act for guidance.

This Comment will examine the evolving role of mid-level health care providers in response to the global physician shortage. This Comment will then illustrate the importance of clear and appropriate mid-level licensure laws by examining the need for a comprehensive licensure scheme for health assistants in the Marshall Islands. Part II describes the global physician shortage and how mid-level providers are being utilized to fill the physician gap in many developing countries. Part II also examines the importance of mid-level licensure laws as quality assurance mechanisms. Part III focuses on the developing state of the Marshall Islands and explores its public health challenges, including its dispersed population and chronic physician shortage. Part III also explores the role of health assistants in the Marshall

¹⁷ E-mail from Justina Langidrik, Secretary of Health, Marshall Islands, to Jeffrey Lane (Dec. 2, 2007, 15:27:00 PST) [hereinafter Langidrik E-mail] (on file with author).

¹⁸ See Keni, *supra* note 13, § 1.

¹⁹ See Langidrik E-mail, *supra* note 17.

²⁰ See Letter from David Gootnick, Director, Int'l Affairs and Trade, U.S. Gov't Accountability Office to U.S. Cong. Comms., 1, 46 (May 25, 2007), 45, available at <http://www.gao.gov/new.items/d07514r.pdf> [hereinafter Gootnick Letter] (stating that prior to an influx of U.S. funding in 2004, Ministry of Health budget shortfalls significantly impacted the outer island health care system leading to "transportation and communication problems, and shortfalls in staffing, equipment, pharmaceuticals, supplies, and facility maintenance").

²¹ See *id.* at 46.

²² See WHO, *supra* note 8, at 16, 21.

Islands and how the role of these providers will likely evolve in response to impending reductions in international aid. Part IV analyzes medical licensure laws in the Marshall Islands and proposes a national health assistant licensure law modeled on WHO recommendations and the Marshall Islands' Nursing Practice Act. Part V considers the political feasibility of enacting a mid-level licensure law in the Marshall Islands today. Part VI concludes by re-examining the need for mid-level licensure laws in countries facing physician shortages and reiterates the need for a Health Assistant Practice Act in the Marshall Islands.

II. DUE TO PHYSICIAN SHORTAGES, THE ROLE OF MID-LEVEL HEALTH CARE PROVIDERS IN MANY DEVELOPING COUNTRIES IS EXPANDING

A recent WHO report concluded that there is a global shortage of more than four million health care providers.²³ Due to high international emigration rates of providers from developing to developed countries,²⁴ the health care provider shortage is disproportionately affecting health systems in developing countries. This provider shortage has also been cited as one of the main obstacles to achieving the Millennium Development Goals related to health in developing countries.²⁵

In response to this provider shortage, many developing countries are increasingly depending on mid-level health care providers ("mid-level providers") to provide primary health care services.²⁶ These providers are known by varying titles including physician assistant, clinical officer, and health assistant and are typically authorized to prescribe medications and perform simple medical procedures.²⁷ Mid-level providers' low immigration rates, short training timelines, low labor costs, and tendency to work in rural areas make them uniquely suited to providing primary health care services in developing countries.²⁸ For these reasons, the roles of mid-level providers in countries facing physician shortages continue to evolve.

²³ See WHO, *supra* note 1, at 12.

²⁴ See Hongoro & McPake, *supra* note 6, at 1451-52.

²⁵ See *id.* at 1451.

²⁶ *Id.* at 1453.

²⁷ See Mullan & Frehywot, *supra* note 7, at 2159.

²⁸ See Delanyo Dovlo, *Using Mid-Level Cadres as Substitutes for Internationally Mobile Health Professionals in Africa. A Desk Review*, 2 HUMAN RESOURCES FOR HEALTH 7, tbl.7 (2004), <http://www.human-resources-health.com/content/2/1/7>.

A. *Due to High Rates of International Immigration and a Lack of Training Capacity, the Physician Shortage Is Most Severe in Developing Countries*

The WHO recently estimated that the world is facing a global shortage of more than four million²⁹ health care providers.³⁰ Due to high rates of international emigration³¹ and a lack of training capacity,³² the global shortage of health care providers disproportionately affects developing countries.

Widely referred to as the “medical brain drain,”³³ large numbers of health care providers emigrate from developing to developed countries every year for better salaries, working, and living conditions.³⁴ The United Nations (“U.N.”) estimated that out of all immigrating physicians, developing countries supply fifty-six percent and only receive eleven percent in return.³⁵ Small island developing countries and least developed countries have the highest brain drain rates.³⁶ The Marshall Islands is considered a small island developing country.³⁷ These high emigration rates significantly inhibit the ability of developing countries to provide skilled health care services to their populations.³⁸

In addition to high international emigration rates, there is also a lack of health care provider training capacity in many developing countries.³⁹ In Sub-Saharan Africa, for example, most countries only have one medical school and some have none.⁴⁰ Similarly, outside of Australia and New Zealand there are only two medical schools in the Pacific Islands.⁴¹ In addition, health-related education institutions that do exist “in low-income countries are [generally] starved of funds.”⁴²

²⁹ See WHO, *supra* note 1, at 12.

³⁰ Only physician, nurse, and midwife shortages were considered in this estimate. *Id.* at 11.

³¹ See Chen et al., *supra* note 3, at 1986.

³² See Narasimhan et al., *supra* note 4, at 1470.

³³ See Wilson, *supra* note 5.

³⁴ See Hongoro & McPake, *supra* note 6, at 1452-53.

³⁵ U.N. CONFERENCE ON TRADE AND DEV. [UNCTAD], *International Trade in Health Services: Difficulties and Opportunities for Developing Countries*, ¶ 26, U.N. Doc. TD/B/Com.1/EM.1/2 (Apr. 7, 1997).

³⁶ Frédéric Docquier et al., *Brain Drain in Developing Countries*, 21 *THE WORLD BANK ECON. REV.* 193, 198 (2007)

³⁷ See UN-OHRLLS, *supra* note 14.

³⁸ See Hongoro & McPake, *supra* note 6, at 1452-53.

³⁹ See Narasimhan et al., *supra* note 4, at 1470.

⁴⁰ See Hongoro & McPake, *supra* note 6, at 1452.

⁴¹ David Water & David Scott, *Doctors in the Pacific*, 181 *MED. J. AUSTRAL.* 597, 599 (2004).

⁴² Narasimhan, *supra* note 4, at 1470.

B. *The Shortage of Health Care Providers in Developing Countries Is a Major Obstacle to Achieving the Millennium Development Goals*

The shortage of health care providers in developing countries has been cited as one of the greatest obstacles to achieving the Millennium Development Goals related to health (“health MDGs”).⁴³ In 2000, 189 countries signed the United Nations Millennium Declaration⁴⁴ that called on all countries to achieve eight humanitarian goals by the year 2015.⁴⁵ Three of these goals directly relate to access to health care providers: reducing child mortality;⁴⁶ improving maternal health;⁴⁷ and combating HIV/AIDS, malaria, and tuberculosis.⁴⁸ All three of these health MDGs have been linked to the availability of health care providers.⁴⁹ Consequently, “[t]he density of [health] workers in a population can make an enormous difference in the effectiveness of MDG interventions.”⁵⁰

Having reached the halfway mark to the 2015 MDG target, the world community is taking stock of its progress, and the results are concerning. In 2007 the United Nations estimated that every single developing world region will fall short of at least one of the targets associated with the health MDGs.⁵¹ Moreover, the same report estimated that Sub-Saharan Africa,

⁴³ See Hongoro & McPake, *supra* note 6, at 1451; see also Chen et al., *supra* note 3, at 1985 (estimating that Sub-Saharan Africa will have to triple its health workforce to come close to achieving the health MDGs).

⁴⁴ See U.N., Millennium Development Goals Indicators, <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm> (last visited Apr. 22, 2008).

⁴⁵ The eight Millennium Development Goals [MDG] include: 1) eradicating extreme poverty and hunger; 2) achieving universal primary education; 3) promoting gender equality and empowering women; 4) reducing child mortality; 5) improving maternal health; 6) combating HIV/AIDS, malaria and other diseases; 7) ensuring environmental sustainability; and 8) developing a global partnership for development. *Id.*

⁴⁶ *Id.* The health MDG of reducing child mortality specifically calls for a two thirds reduction in mortality rates of children under the age of five. *Id.*

⁴⁷ *Id.* The health MDG of improving maternal health specifically calls for a three quarters reduction in the maternal mortality ratio. *Id.*

⁴⁸ See *id.* The health MDG of combating HIV/AIDS, malaria and other diseases calls for halting and reversing the spread of HIV by 2015. *Id.* This MDG also calls for halving and reversing the spread of malaria and other major diseases, especially tuberculosis, by 2015. *Id.*

⁴⁹ Both child mortality rates and maternal mortality rates have been linked to the availability of health care providers. See Hongoro & McPake, *supra* note 6, at 1451 (citing Sudhir Anand & Till Bärnighausen *Human Resources and Health Outcomes*, 371 LANCET 668 (2004)). In addition, the failure to increase the number of HIV patients receiving antiretroviral therapy has also been linked to an inadequate number of health care providers. See Paul Simao, *Africa AIDS War Undercut by Health Worker Crisis*: MSF, REUTERS (May 24, 2007).

⁵⁰ See Chen et al., *supra* note 3, at 1984.

⁵¹ See U.N. STATISTICS DIVISION, MILLENNIUM DEVELOPMENT GOALS: 2007 PROGRESS CHART (2007), available at http://unstats.un.org/unsd/mdg/MDG_Report_2007_Progress_Chart_en.pdf [hereinafter UNSD].

South and Southeast Asia, and Oceania⁵² will all miss at least five out of six targets associated with the health MDGs.⁵³

C. *Due to the Global Provider Shortage, Developing Countries Are Increasingly Depending on Mid-Level Health Care Providers to Provide Critical Health Care Services*

As a result of the global physician shortage, mid-level health care providers “are increasingly becoming the main providers of health services in many countries.”⁵⁴ At least eleven Pacific Island nations⁵⁵ and twenty-five Sub-Saharan African countries have created categories of mid-level health care providers.⁵⁶ The category of mid-level providers generally includes health care clinicians who have received less training than a full physician, but more than a nurse.⁵⁷ The titles of mid-level providers vary from country to country but include clinical officer, physician assistant,⁵⁸ and health assistant.⁵⁹ Mid-level providers who have already completed a nursing degree⁶⁰ are typically referred to as “nurse practitioners.”⁶¹

Unlike physicians who are granted general licenses to practice medicine, mid-level providers are only authorized to provide a limited set of clinical activities.⁶² These activities typically include diagnosing illnesses, prescribing medication, and performing simple clinical procedures.⁶³ However, their precise scopes of practice vary. For example, in some countries, such as the Marshall Islands, mid-level providers act as general

⁵² Oceania includes developing countries in the Western Pacific. See Millennium Development Indicators: World and Regional Groupings: The Official United Nations Site for the MDG Indicators, <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/RegionalGroupings.htm> (last visited Apr. 20, 2008) (listing countries in each regional group).

⁵³ See UNSD, *supra* note 51.

⁵⁴ See Hongoro & McPake, *supra* note 6, at 1453.

⁵⁵ See WHO, *supra* note 8, at 4.

⁵⁶ See Mullan & Frehywot, *supra* note 7, at 2159.

⁵⁷ *Id.* at 2158-59.

⁵⁸ See *id.* at 2158.

⁵⁹ WHO, *supra* note 8, at 3.

⁶⁰ While both nurse-based and non-nurse-based mid-level providers can effectively provide essential health services, non-nurse-based mid-level programs have two main advantages over nurse-based programs. The first is that mid-level providers with nursing degrees pose the same international emigration risk as regular nurses. See Hongoro & McPake, *supra* note 6, at 1453. Secondly, many developing countries, including many countries in Micronesia, are already facing nursing shortages and, thus, creating nurse-based mid-level programs could deplete already stretched nursing workforces. See WHO, *supra* note 8, at 11. For these reasons, non-nurse-based mid-level programs may be a better option for countries with high international emigration rates and pre-existing nursing shortages.

⁶¹ WHO, *supra* note 8, at 3.

⁶² Barbara Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymaker*, 19 YALE J. ON REG. 301, 311 (2002).

⁶³ See Mullan & Frehywot, *supra* note 7, at 2159.

practitioners.⁶⁴ In contrast, in other countries, such as Kenya, mid-level providers can specialize in anesthesia, obstetrics, or one of a number of other specialty areas.⁶⁵

1. Mid-Level Providers Offer Many Advantages over Physicians in Developing Countries

Mid-level providers offer many advantages over traditional physicians including lower emigration rates, shorter training programs, lower labor and training costs, and a tendency to work in rural areas.⁶⁶ In addition, recent studies indicate that mid-level providers provide a similar quality of care as physicians in certain circumstances.⁶⁷

The first and perhaps most important advantage of mid-level providers is their low rate of international migration.⁶⁸ This is largely due to mid-level credentials not being recognized in developed countries.⁶⁹ This makes training mid-level providers a much better investment for developing countries with high emigration rates.

Second, mid-level providers can be trained in less time than physicians.⁷⁰ Training programs for mid-level providers in Oceania range from one to four years⁷¹ which is significantly less than the five years, at minimum, that it takes to train a physician.⁷² In addition to shorter training times, mid-level providers also provide two significant financial advantages over physicians. First, shorter training timelines translate into lower training costs and, second, mid-level providers do not demand the same salaries as physicians lowering their annual labor costs.⁷³

Finally, mid-level providers also tend to be more inclined to work in rural areas than their physician counterparts.⁷⁴ For example, a study in Mozambique revealed that seven years after graduation more than eighty percent of mid-level providers remained at district-level hospitals, whereas

⁶⁴ See Keni, *supra* note 13, § 1.

⁶⁵ See Mullan & Frehywot, *supra* note 7, at 2159.

⁶⁶ See Dovlo, *supra* note 28, tbl.7.

⁶⁷ P Venning et al., *Randomised Controlled Trial Comparing Cost Effectiveness of General Practitioners and Nurse Practitioners in Primary Care*, 320 *BMJ* 1048, 1048. (2000); see also Garvey Chilopora et al., *Postoperative Outcome of Caesarean Sections and Other Major Emergency Obstetric Surgery by Clinical Officers and Medical Officers in Malawi*, 5 *HUMAN RESOURCES FOR HEALTH* 17 (2007).

⁶⁸ Hongoro & McPake, *supra* note 6, at 1453.

⁶⁹ *Id.*

⁷⁰ See Dovlo, *supra* note 28, at 9.

⁷¹ See WHO, *supra* note 8, at 4.

⁷² Hongoro & McPake, *supra* note 6, at 1453.

⁷³ *Id.*

⁷⁴ *Id.*

no physicians remained at the district hospital seven years after graduation.⁷⁵ In the Marshall Islands, the difficulty of recruiting physicians to its outer islands was the main impetus for training mid-level health assistants to serve the outer island communities.⁷⁶

In addition to these advantages over physicians, comparative analyses of health outcomes between mid-level providers and physicians indicate that in certain circumstances there is no significant difference in the quality of care provided by mid-level providers and physicians. One such study from Great Britain concluded that mid-level providers provide the same quality of primary care as physicians.⁷⁷ A similar study in Malawi comparing health outcomes of caesarean sections performed by mid-level providers and physicians also found no significant difference in health outcomes.⁷⁸ These studies indicate that at least in terms of basic health care, mid-level providers likely provide a similar quality of care as physicians.

Taken together, mid-level providers' relatively low emigration rates, short training timelines, low labor and training costs, and tendency to work in rural areas make them extremely valuable in developing countries. When combined with similar health outcomes as physicians for certain basic health services, it is not surprising that in many developing countries mid-level providers are assuming the role of primary providers of health care.⁷⁹

2. *To Protect Patient Safety, Mid-Level Providers Are Only Authorized to Provide a Limited Scope of Clinical Services*

As mid-level providers become the primary providers of health care in many developing countries,⁸⁰ they are also providing an increasingly broad array of clinical services.⁸¹ However, “[i]f [these providers] are not properly regulated . . . there will be serious limitations to the . . . quality of services they provide.”⁸² Thus, restricting the scope of practice of mid-level providers to include only those services for which they have been adequately trained is essential to protecting patient safety.⁸³

⁷⁵ C. Pereira et al., *Meeting the Need for Emergency Obstetric Care in Mozambique: Work Performance and Histories of Medical Doctors and Assistant Medical Officers Trained for Surgery*, 114 *BJOG: AN INT'L J. OF OBSTETRICS AND GYNECOLOGY* 1530, 1533 (2007).

⁷⁶ Keni, *supra* note 13, § 5.

⁷⁷ See Venning et al., *supra* note 67, at 1048.

⁷⁸ See Chilopora et al., *supra* note 67.

⁷⁹ Hongoro & McPake, *supra* note 6, at 1453.

⁸⁰ *Id.*

⁸¹ See Hongoro & McPake, *supra* note 6, at 1453.

⁸² See Dovlo, *supra* note 28, at 10.

⁸³ See WHO, *supra* note 8, at 16.

Scope of practice limitations are typically enacted through medical licensure laws that are established to ensure that providers meet the basic minimum standards for competency.⁸⁴ Mid-level training programs focus on limited sets of clinical competencies, allowing for shorter programs and fewer prerequisites. To protect patient safety, the legal scope of practice of these workers should be limited to this set of competencies.⁸⁵

Due to the expanding role of mid-level providers in developing countries, mid-level providers around the world are increasingly being documented practicing outside of their legal scope of practice.⁸⁶ This usually occurs when prescribing medications, performing minor surgical procedures, and responding to emergencies.⁸⁷ Exceeding their scope of practice could pose a serious risk to patient safety if providers are practicing beyond their capabilities. In addition to potentially compromising patient safety, exceeding one's licensed scope of practice can also expose mid-level providers to legal liability.⁸⁸ Licensure regulations typically subject providers to fines for violating their licensure limitations.⁸⁹

While scope of practice limitations are important to providing quality care, unnecessarily restrictive scopes of practice can also inhibit the impact of these providers.⁹⁰ The WHO has noted that many laws regulating the activities of mid-level providers are "outdated and unduly restrictive."⁹¹ These restrictive scopes of practice often result from political pressure from physician associations and physician-based licensing boards that oppose expanding the role of mid-level providers out of fear of professional competition.⁹² To ensure that countries are striking an appropriate balance between the growing need for providers and the need to protect patient safety, the WHO has called on countries to review their mid-level licensure laws to ensure that they appropriately define the roles of these providers.⁹³

⁸⁴ EDGAR NECOCHEA, CAPACITY PROJECT, BUILDING STRONGER HUMAN RESOURCES FOR HEALTH THROUGH LICENSURE, CERTIFICATION AND ACCREDITATION, 1-2 (2006), available at http://www.capacityproject.org/images/stories/files/techbrief_3.pdf.

⁸⁵ See WHO, *supra* note 8, at 16 (stating that mid-level provider scope of practice laws should include those services "for which they have been trained").

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ See, e.g., Clinical Officers (Training, Registration and Licensing) Act, (1989) Cap. 260 § 13 (Kenya) [hereinafter Clinical Officers Act] (providing for fines and imprisonment for clinical officers who fail to comply with restrictions on their private practice licenses).

⁹⁰ See Safriet, *supra* note 62, at 312 (observing that "what [mid-level providers] are able to do is always several years (or more) ahead of what they are permitted to do").

⁹¹ WHO, *supra* note 8, at 16.

⁹² See Hongoro & McPake, *supra* note 6, at 1452; see also Dovlo, *supra* note 28, at 8.

⁹³ WHO, *supra* note 8, at 16.

One developing country that is utilizing mid-level providers⁹⁴ to address its chronic physician shortage but has failed to satisfy the WHO recommendations for mid-level provider licensure laws is the Marshall Islands.

III. HEALTH ASSISTANTS PLAY A CRITICAL ROLE IN ADDRESSING THE MARSHALL ISLANDS' CHRONIC PHYSICIAN SHORTAGE

Spread across thousands of square miles of Pacific Ocean, the Marshall Islands established a category of mid-level providers to provide critical primary health care services to its remote island communities.⁹⁵ These mid-level providers, known as health assistants, operate a network of sixty-two outer island health centers.⁹⁶ The network of health centers allows outer island residents to access basic primary health care services and also acts as a triage system for transferring complicated cases to the main hospital in the capital city of Majuro.⁹⁷

While this system has worked effectively for years, evidence of past budget shortfalls⁹⁸ indicates that impending reductions in international aid will lead to breakdowns in the radio communication system between the health centers and the main Majuro hospital.⁹⁹ To ensure that health assistants are practicing appropriately and are adequately trained to deal with emergency situations, the Marshall Islands should enact a national licensure scheme that clearly defines the roles of these providers.

A. *The Marshall Islands Faces a Number of Public Health Challenges, Including a Chronic Shortage of Health Care Providers*

The Marshall Islands' Constitution requires the Marshall Islands' government to provide health care services to its population.¹⁰⁰ Article 11, Section 15 of the Marshall Islands Constitution recognizes that the people of the Marshall Islands have a right to health care. The Constitution further states that the government of the Marshall Islands has the "obligation to take every step reasonable and necessary to provide these services."¹⁰¹ Two of the greatest obstacles to fulfilling this constitutional obligation are the

⁹⁴ Keni, *supra* note 13, § 1.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ See Langidrik E-mail, *supra* note 17.

⁹⁸ See Gootnick Letter, *supra* note 21, at 45.

⁹⁹ *Id.*

¹⁰⁰ CONST. art XI, § 15 (1979) (Marsh. Is.).

¹⁰¹ *Id.*

geographic makeup of the Marshall Islands¹⁰² and a lack of health care providers.¹⁰³

The Marshall Islands consists of 1225 islands spread across an expanse of the Pacific about one-third the size of the United States.¹⁰⁴ Nearly seventy percent of the Marshall Islands' population lives in the country's two largest cities, Ebeye and Majuro.¹⁰⁵ While small in comparison to other cities, Ebeye and Majuro have two of the highest population densities in the world.¹⁰⁶ In contrast to the densely populated streets of Ebeye and Majuro, more than 17,000 Marshallese residents live on isolated outer atolls.¹⁰⁷ One of the most common modes of transportation between outer islands is by flat bottom boat—a trip that in some instances can take many days.¹⁰⁸ Further complicating these demographics is a high population growth rate which is expected to double the Marshall Islands' population by 2020.¹⁰⁹

In addition to these geographic and demographic challenges, the Marshall Islands also faces a chronic shortage of physicians.¹¹⁰ In 2004 the Marshall Islands only had thirty-two physicians¹¹¹ for more than 60,000 residents.¹¹² In 2006 the Marshall Islands Ministry of Health concluded that the country faces a persistent lack of qualified health care providers, including physicians, and that this “persistent shortage [of health care providers] has affected the Ministry's ability to diagnose and provide care to patients.”¹¹³ The WHO has also cited health care provider migration as one of the greatest challenges faced by the Marshall Islands' health system.¹¹⁴

Adding to the provider shortage is a lack of local training institutions. The Marshall Islands' college has a nurse training program,¹¹⁵ however,

¹⁰² See Keni, *supra* note 13, § 1.

¹⁰³ See Gootnick Letter, *supra* note 20, at 45.

¹⁰⁴ Howard French, *Majuro Journal: A Pacific Puzzle: Connecting Dots into a Nation*, N.Y. TIMES, June 30, 2001.

¹⁰⁵ See WHO, COUNTRY PROFILE OF THE REPUBLIC OF THE MARSHALL ISLANDS 2000 (2000).

¹⁰⁶ *Id.*

¹⁰⁷ Keni, *supra* note 13, § 1.

¹⁰⁸ See WHO, *supra* note 8, at 1.

¹⁰⁹ See WHO, *supra* note 105.

¹¹⁰ See Gootnick Letter, *supra* note 20, at 46.

¹¹¹ MARSHALL ISLANDS MINISTRY OF HEALTH, MINISTRY OF HEALTH ANNUAL REPORT 2004, 38 (2004) [hereinafter REPORT 2004].

¹¹² CIA, WORLD FACTBOOK, MARSHALL ISLANDS, <https://www.cia.gov/library/publications/the-world-factbook/geos/rm.html> (last visited Apr. 24, 2008).

¹¹³ See Gootnick Letter, *supra* note 20, at 46.

¹¹⁴ WHO, REGIONAL OFFICE FOR THE WESTERN PACIFIC, MARSHALL ISLANDS HEALTH SYSTEM, http://www.wpro.who.int/countries/msi/national_health_priorities.htm (last visited Apr. 24, 2008).

¹¹⁵ College of the Marshall Islands, Nursing and Allied Health Program, <http://www.cmi.edu/academics/nah.html> (last visited Apr. 22, 2008).

there is no medical school in the Marshall Islands.¹¹⁶ Of the few native physicians practicing in the Marshall Islands, many were trained at the University of Hawaii in an exchange program that ended in 1996.¹¹⁷ To address the lack of native physicians, the Ministry of Health has been forced to hire an increasing number of foreign physicians. In 2004, twenty-five of the thirty-two physicians employed by the Ministry of Health had been hired from outside the Marshall Islands.¹¹⁸ This has led to an inordinate proportion of the Ministry of Health's budget being spent on foreign physician salaries, which are significantly higher.¹¹⁹

Anecdotal evidence illustrates the impact of the provider shortage on the Marshall Islands' health system. In 2005 the Marshall Islands purchased an expensive computed tomography ("CT") scanner for the main hospital in Majuro.¹²⁰ However, as of 2006 the scanner had not been used in over a year because the only person qualified to operate the scanner had either emigrated or left the hospital.¹²¹ This example illustrates the great impact that the loss of even one provider can have on the capacity of a developing health system.

B. Health Assistants Play a Critical Role in Fulfilling the Government's Obligation to Provide Health Services to All Marshallese

In light of its chronic physician shortages¹²² and a constitutional obligation to provide health care services to its outer island residents,¹²³ the Marshall Islands created a category of mid-level health care providers known as health assistants.¹²⁴ Candidates for the health assistant training program are recruited from the indigenous outer island populations.¹²⁵ The training program consists of eighteen months and emphasizes identifying cases that need to be referred to the central hospital in Majuro.¹²⁶

¹¹⁶ See Water & Scott, *supra* note 41, at 597 (stating that the only two medical schools in Oceania outside of Australia and New Zealand are located in Fiji and Papua New Guinea).

¹¹⁷ See Gregory Dever, *The Role of Low Cost Communications in Health in the Redevelopment of the Indigenous Physician Workforce Among Selected Jurisdictions of the US-Associated Pacific Islands*, 7 *PACIFIC HEALTH DIALOGUE* 63, 65-66 (2000).

¹¹⁸ REPORT 2004, *supra* note 111, at 38.

¹¹⁹ WHO, COUNTRY HEALTH INFORMATION PROFILE FOR THE REPUBLIC OF THE MARSHALL ISLANDS 2000 (2000), available at <http://marshall.csu.edu.au/Marshalls/html/health/WHOReport2000.html>.

¹²⁰ Gootnick Letter, *supra* note 20, at 46.

¹²¹ *Id.*; see also Transcript of Marshall Islands Chamber of Commerce Forum on Health, <http://www.majurochamber.net/Health%20Forum%207-12-06.htm> (last visited Jan. 5, 2008).

¹²² Gootnick Letter, *supra* note 20, at 46.

¹²³ CONST. art XI, § 15 (1979) (Marsh. Is.).

¹²⁴ Keni, *supra* note 13, § 1.

¹²⁵ *Id.* § 2.

¹²⁶ *Id.* § 5.

The health assistants are responsible for operating sixty-two health centers strategically located throughout the outer islands. Together these health centers are responsible for providing health services to 17,000 people spread across more than 1,800,000 square kilometers.¹²⁷ The health center facilities are simple structures powered only by solar panels.¹²⁸ Each health center is also supposed to have a two-way radio to communicate with physicians located at the main hospital in Majuro.¹²⁹

This radio communication system is a critical component of the outer island health care system.¹³⁰ The radio system allows the health assistants to contact physicians in Majuro for guidance regarding how to treat certain conditions and to determine whether a patient should be transferred to the Majuro hospital. In 2003 the number of referrals from each health center ranged from zero to fourteen.¹³¹ The Ministry of Health cites this radio system as one of the key checks on the role of the health assistants; however, as discussed below,¹³² this radio system is becoming increasingly unreliable.

The outer island health centers and the health assistants who operate these centers have been critical in fulfilling the Marshall Islands' constitutional obligations to provide health care to the Marshallese people. However, impending reductions in international aid could challenge the stability of the outer island health care system.

C. *Impending Reductions in International Aid Will Likely Increase the Burden on the Outer Island Health Assistants*

Due to years of financial assistance from the United States, the Marshall Islands Ministry of Health has become dependent on U.S. financial assistance to pay for its health programs. For example, in 2006, fifty percent of the Marshall Islands health budget was provided by U.S. financial assistance.¹³³ However, in the coming years the amount of financial assistance from the United States will steadily decrease.¹³⁴ Unless action is

¹²⁷ Keni, *supra* note 13, § 1.

¹²⁸ Photos of the health centers can be found in the 2006 Marshall Islands Ministry of Health 2006 Annual Report. See MARSHALL ISLANDS MINISTRY OF HEALTH, MINISTRY OF HEALTH ANNUAL REPORT 2006 67 (2006) [hereinafter REPORT 2006].

¹²⁹ Keni, *supra* note 13, § 1.

¹³⁰ See Langidrik E-mail, *supra* note 17.

¹³¹ MARSHALL ISLANDS MINISTRY OF HEALTH, MINISTRY OF HEALTH ANNUAL REPORT 2003 43 (2003).

¹³² See *infra* Part III.C.

¹³³ See Gootnick Letter, *supra* note 20, at 44.

¹³⁴ *Id.* at 46.

taken to address this reduction, the Marshall Islands' health system will likely face significant budget shortfalls.

The Marshall Islands' dependence on U.S. financial assistance arose due to more than a decade of U.S. nuclear testing on the Marshall Islands in the 1940s and 1950s. Between 1946 and 1958 the United States detonated sixty-seven nuclear devices on the Marshall Islands.¹³⁵ In 1986 the United States entered into a Compact of Free Association ("Compact") with the Marshall Islands that provided for reparations for individuals affected by the testing and for the country as a whole.¹³⁶ A large portion of the national Compact funding has been dedicated for health care.¹³⁷ However, in 2003, the United States and the Marshall Islands renegotiated the Compact, which now calls for annual reductions in United States funding through 2023.¹³⁸ In the coming years, instead of sending financial assistance dedicated for existing programs, the United States will contribute capital to a trust fund for the Marshall Islands to provide a source of long-term revenue.¹³⁹

The effects of the impending budget restrictions can be anticipated by looking at the consequences of the reduction in U.S. funding in 2004. During this period, only forty-five of the sixty-two health centers in the Marshall Islands were open for operation.¹⁴⁰ The remaining centers were closed due to either disrepair or a lack of health assistants.¹⁴¹ As a result, some health assistants were forced to treat patients in their own homes, while others were asked to staff two health centers concurrently.¹⁴²

In addition to infrastructure deterioration and human resources shortages, the radio communication system also broke down during the 2004 budget shortfall. A 2005 report by the Ministry of Health concluded that thirty-five percent of the health assistants did not have functioning radios at their health centers during this time.¹⁴³ In emergencies, these health assistants would travel to the nearest government council to use their radio, even though in some cases the nearest government council was located on a separate island a significant distance away.¹⁴⁴ As previously discussed, the health center radios are critical to the outer island communication and triage

¹³⁵ Ian Anderson et al., *Indigenous Health in Australia, New Zealand and the Pacific*, 367 LANCET 1775, 1780 (2006).

¹³⁶ *Id.*

¹³⁷ See Gootnick Letter, *supra* note 20, at 43.

¹³⁸ *Id.* at 1.

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 45.

¹⁴¹ *Id.*

¹⁴² *Id.* at 71.

¹⁴³ ASIAN DEV. BANK, HEALTH AND POPULATION PROJECT IN THE MARSHALL ISLANDS 33 (2005).

¹⁴⁴ *Id.*

system.¹⁴⁵ While some new radios have been purchased, the 2006 Ministry of Health Annual Report estimated that twenty percent of the health centers still do not have working radios.¹⁴⁶

While some of these budget issues have been addressed since the new Compact was signed in 2004,¹⁴⁷ the breakdowns that occurred during the 2004 shortfall indicates the impact that future reductions may have on the outer island health care system. In addition to these effects, the aid reductions may also force the Ministry of Health to scale back its foreign trained physician workforce, which could also increase the burden on the outer island health assistants. Before these aid reductions begin to significantly impact the national health budget, the Marshall Islands should enact a comprehensive regulatory scheme that clearly defines the role of the outer island health assistants.

IV. THE MARSHALL ISLANDS SHOULD ENACT A MID-LEVEL LICENSURE LAW THAT CLARIFIES THE ROLE OF HEALTH ASSISTANTS

The WHO has recommended that mid-level provider licensure laws clearly and appropriately define mid-level providers' scope of practice, degree of autonomy, initial and continuing education requirements, and disciplinary mechanisms. The Marshall Islands' health assistants are currently licensed under the Marshall Islands' Health Services Act of 1983,¹⁴⁸ which fails to satisfy three of the WHO's recommendations¹⁴⁹ for effective mid-level provider licensure laws. To ensure that these providers are effectively trained and regulated, the Marshall Islands should enact a comprehensive health assistant licensure law that satisfies all four WHO recommendations for effective mid-level provider licensure laws. The Marshall Islands can model this health assistant licensure law on its own nursing licensure law, the Nursing Practice Act.

¹⁴⁵ Langidrik E-mail, *supra* note 17.

¹⁴⁶ REPORT 2006, *supra* note 128, at 67-68 (2006).

¹⁴⁷ See Gootnick Letter, *supra* note 20, at 45 (stating that some of the health centers that were closed during the budget shortfall have been reopened).

¹⁴⁸ Health Services Act, 19 M.I.R.C. 1, § 106 (1983) (Marsh. Is.) (authorizing the Medical Board to issue licenses to practice in any category of health service).

¹⁴⁹ See WHO, *supra* note 8, at 21.

A. *The Marshall Islands' Health Assistants Are Licensed Under the Health Services Act*

The Marshall Islands' health assistants are licensed under the Health Services Act. In 1983 the Marshall Islands Nitijela (Parliament) enacted the Health Services Act to regulate all categories of health care providers practicing in the Marshall Islands. The Medical Board created under this act is granted the authority to issue licenses for persons practicing in "any category of health service."¹⁵⁰ The Health Services Act defines "any category of health service" as including "(i) medicine; (ii) surgery; (iii) dentistry; (iv) nursing; or (v) any other related health service."¹⁵¹ The Marshall Islands' health assistants are licensed under this law,¹⁵² however, its provisions provide little guidance to health assistants regarding their clinical roles or continuing education requirements.

B. *The Health Services Act Fails to Satisfy Three WHO Recommendations for Effective Mid-Level Provider Licensure Laws*

In light of the evolving roles of mid-level health care providers in developing countries, the WHO has called on all countries utilizing mid-level health care providers to review their mid-level provider licensure laws to ensure that they appropriately and clearly define four key issues: 1) scope of practice, 2) physician oversight requirements, 3) educational requirements, and 4) accountability standards.¹⁵³ The Marshall Islands' Health Services Act fails to satisfy three of these recommendations.

The Marshall Islands has a history of utilizing WHO recommendations in drafting national health policy¹⁵⁴ and, thus, would likely look to these recommendations in evaluating their medical licensure laws. The Marshall Islands has adopted the WHO's definition of primary care in defining the government's obligation under section 15 of its Constitution to

¹⁵⁰ Health Services Act, 19 M.I.R.C. 1, § 106 (1983) (Marsh. Is.).

¹⁵¹ *Id.* § 102.

¹⁵² Section 103(2)(a) of the Health Services Act creates an exception from the licensing requirement for persons employed by the government of the Marshall Islands. *Id.* § 103(2)(a). Health assistants are employed by the Public Service Commission of the Marshall Islands, a governmental agency. See Keni, *supra* note 13, § 5. Therefore, pursuant to section 103(2) of the Health Services Act, health assistants should technically be exempted from the Medical Board's licensure jurisdiction. However, a former employee of the Marshall Islands Ministry of Health has confirmed that the health assistants are licensed under the Medical Board. E-mail from Bhalachandra Keni to Jeffrey Lane (Apr. 3, 2008, 20:17:00 PST) (on file with author).

¹⁵³ WHO, *supra* note 8, at 21.

¹⁵⁴ MARSHALL ISLANDS MINISTRY OF HEALTH, MINISTRY OF HEALTH ANNUAL REPORT 2002 7 (2002) [hereinafter REPORT 2002].

provide primary health care services.¹⁵⁵ The Marshall Islands has also adopted WHO recommendations regarding standards of disease surveillance¹⁵⁶ and for the treatment of tuberculosis.¹⁵⁷ The Marshall Islands Ministry of Health has cited the WHO policy recommendations for tuberculosis as “instrumental in contributing to increasing the cure rate of TB cases.”¹⁵⁸ In addition, the Marshall Islands consulted with the WHO in designing its Health Assistant Training Program.¹⁵⁹ Consequently, the Marshall Islands would likely look to the WHO’s recommendations for effective mid-level provider licensure laws in evaluating the effectiveness of its own mid-level provider licensure scheme.

The first WHO recommendation for effective mid-level licensure laws calls for clearly defining mid-level providers’ scope of practice.¹⁶⁰ As discussed above, scope of practice limitations are necessary to ensure that mid-level providers are not providing services for which they are not qualified.¹⁶¹ The Health Services Act does not provide any guidance regarding the legal scope of practice of health assistants.

The second WHO recommendation calls on countries to clearly define the degree of autonomy of mid-level providers.¹⁶² Degree of autonomy generally refers to the level of physician oversight required. Degree of autonomy regulations have been carried out in different ways. For instance, in some states in the United States, physician assistants have to submit practice arrangement proposals to a licensing board before being issued a license to practice.¹⁶³ In other countries, private practice licenses specify whether mid-level providers are permitted to practice independently or must join a pre-existing practice.¹⁶⁴ The Health Services Act does not define the degree of autonomy of health assistants in the Marshall Islands.

The third WHO recommendation calls for defining initial and continuing education requirements.¹⁶⁵ The Marshall Islands has satisfied this requirement by requiring all health assistants to complete the

¹⁵⁵ CONST. art XI, § 15 (1979) (Marsh. Is.).

¹⁵⁶ REPORT 2002, *supra* note 154, at 18.

¹⁵⁷ *Id.* at 20.

¹⁵⁸ *Id.*

¹⁵⁹ See Keni, *supra* note 13, § 5.

¹⁶⁰ See WHO, *supra* note 8, at 16.

¹⁶¹ See *id.*

¹⁶² See WHO, *supra* note 8, at 16.

¹⁶³ See, e.g., WASH. REV. CODE § 18.71A.030 (requiring physician assistants in the state of Washington to submit practice arrangement proposals before being allowed to practice).

¹⁶⁴ See, e.g., Clinical Officers (Training, Registration and Licensing) Act, (1989) Cap. 260 § 11 (Kenya) (granting the Clinical Officers Council the authority to issue private practice licenses that allow clinical officers to practice independently or require them to join a preexisting practice).

¹⁶⁵ See WHO, *supra* note 8, at 21.

government's Health Assistant Training Program.¹⁶⁶ However, in addition to initial education requirements, the WHO has also recommended that mid-level providers be required to undergo continuing education.¹⁶⁷ At least one study indicates that mid-level providers begin to lose knowledge learned during their training program less than one year after graduation.¹⁶⁸ Similar studies have led the WHO to conclude that mid-level "[c]ontinuing education is vital for keeping up [mid-level provider] motivation and for ensuring competent practice."¹⁶⁹ In the United States, mid-level providers are required to attend a certain number of continuing education classes every year to renew their licenses.¹⁷⁰ Currently, the Health Services Act does not require health assistants or any other health care provider to attend continuing education programs to renew their licenses.¹⁷¹

Finally, to ensure that mid-level providers comply with the scope of practice, autonomy of practice, and education regulations, the WHO has also recommended that mid-level licensure laws clearly define accountability standards for enforcing these regulations.¹⁷² Accountability mechanisms allow a medical licensure board to review the ongoing practice of health care providers.¹⁷³ Reasons for invoking disciplinary procedures may include exceeding the authorized scope of practice, ignoring physician oversight requirements, or negligent treatment of patients.¹⁷⁴ Section 110 of the Health Services Act satisfied this recommendation by granting the Medical Board the power to discipline persons who violate the provisions of the act.

The Health Services Act fails to satisfy three of the WHO recommendations for effective mid-level provider licensure laws. As illustrated by the scenario at the beginning of this Comment, clear scope of practice, degree of autonomy, and continuing education regulations for mid-level providers are critical to ensuring safe and effective care in areas facing physician shortages. To ensure that health assistants are appropriately trained and regulated, the Marshall Islands Nitijela should enact a

¹⁶⁶ See Keni, *supra* note 13, § 2.

¹⁶⁷ See WHO, *supra* note 8, at 17.

¹⁶⁸ David Ofori-Adjei & Daniel Arhinful, *Effect of Training on the Clinical Management of Malaria by Medical Assistants in Ghana*. 42 SOC. SCI. MED. 1169, 1169 (1996).

¹⁶⁹ WHO, *supra* note 8, at 17.

¹⁷⁰ See, e.g., WASH. ADMIN. CODE 246-918-180 (requiring physician assistants to complete one hundred hours of continuing medical education every two years to renew their license to practice).

¹⁷¹ See Health Services Act, 19 M.I.R.C. 1, § 112 (1983) (Marsh. Is.) (the Health Services Act mandates that the Department of Health Services offer continuing education programs when appropriate but does not require health care providers to attend these programs to renew their licenses).

¹⁷² WHO, *supra* note 8, at 21.

¹⁷³ See NECOCHEA, *supra* note 84, at 2.

¹⁷⁴ See, e.g., Clinical Officers (Training, Registration and Licensing) Act, (1989) Cap. 260 § 15 (Kenya).

comprehensive health assistant licensure law that satisfies all four WHO recommendations. In drafting this law, the Nitijela should look to its own Nursing Practice Act for guidance.

C. To Meet the WHO Recommendations, the Marshall Islands Should Enact a Health Assistant Licensure Law Modeled on the Marshall Islands' Nursing Practice Act

To meet the WHO recommendations for mid-level provider licensure laws, the Marshall Islands should enact a health assistant licensure law modeled on its own Nursing Practice Act. The WHO recommended that all countries clearly and appropriately define mid-level providers' 1) scope of practice, 2) autonomy of practice, 3) educational requirements, and 4) accountability mechanisms.¹⁷⁵ By enacting a licensure law for health assistants similar to the Nursing Practice Act,¹⁷⁶ the Marshall Islands can fulfill all four WHO recommendations. This Comment will refer to this proposed law as the Health Assistant Practice Act.

1. The Health Assistant Practice Act Should Create a Health Assistant Licensure Board Similar to the Board of Nurse Examiners

To institutionalize the WHO guidelines and ensure that health assistants' scope of practice, degree of autonomy and educational requirements are not unduly restricted by a physician-based licensure board, the Health Assistant Practice Act should create an independent health assistant licensure board similar to the Board of Nurse Examiners. Section 205 of the Nursing Practice Act establishes an independent licensure board, known as the Board of Nurse Examiners. The Board of Nurse Examiners consists of seven members with varying backgrounds in nursing.¹⁷⁷ The Nursing Practice Act states that the board must consist of three registered nurses, one licensed practical nurse, one registered nurse on faculty at the School of Nursing, one nurse midwife or nurse-practitioner, and one non-nurse health consumer.¹⁷⁸ Membership on the board is completely voluntary¹⁷⁹ and each member holds a two-year term.¹⁸⁰

¹⁷⁵ WHO, *supra* note 8, at 21.

¹⁷⁶ See Nursing Practice Act, 19 M.I.R.C. c. 2 (1995) (Marsh. Is.).

¹⁷⁷ *Id.* §206.

¹⁷⁸ *Id.*

¹⁷⁹ See *id.* §209.

¹⁸⁰ *Id.* §207.

The Nursing Practice Act grants the Board of Nurse Examiners the exclusive power to regulate the nursing profession. These powers specifically include the authority to regulate nursing education requirements, issue and review nursing licenses, collect data regarding the practice of nursing, and discipline nurses who violate the nursing regulations.¹⁸¹

The Health Assistant Practice Act should create a similar licensure board for health assistants. Similar to the Board of Nurse Examiners, the health assistant licensure board should be made up primarily of health assistants.¹⁸² In addition, the board should also have at least one faculty member from the Health Assistant Training Program to ensure coordination between the licensure board and the health assistant training curriculum.

By granting the health assistant licensing board powers similar to the Board of Nurse Examiners, the Health Assistant Practice Act could also ensure that the health assistants' scope of practice and degree of autonomy are appropriately regulated.¹⁸³ This power would allow the Marshall Islands to avoid political pressure from physician board members who have unnecessarily restricted scopes of practice of mid-level providers in other countries.¹⁸⁴

In addition, the Board of Nurse Examiners also has the power to collect data regarding the practice of nursing in the Marshall Islands. Granting the health assistant licensure board similar power would allow it to continuously evaluate the clinical capabilities of health assistants and adjust their licensed scope of practice accordingly. For these reasons, creating a separate licensing board made up of health assistants would be a critical step towards appropriately defining the role of the Marshall Islands' health assistants.

2. *The Health Assistant Practice Act Should Delineate the Initial Scope of Practice of Health Assistants but Should Also Grant the Licensing Board the Power to Amend this Scope in the Future*

Pursuant to the WHO recommendations, the Health Assistant Practice Act should clearly and appropriately define health assistants' scope of practice.¹⁸⁵ Section 203 of the Nursing Practice Act defines the scope of

¹⁸¹ *Id.* §212.

¹⁸² *See id.* § 206.

¹⁸³ By creating a separate licensing board for health assistants the Marshall Islands could ensure that health assistants' scope of practice and autonomy of practice are not unnecessarily restrictive. *See* WHO, *supra* note 8, at 16.

¹⁸⁴ *See* Dovlo, *supra* note 28, at 8.

¹⁸⁵ *See* WHO, *supra* note 8, at 16.

practice of nurses. This section also includes a definition for the scope of practice of nurse practitioners. As previously discussed, nurse practitioners are mid-level health care providers who have completed a nursing program prior to being trained as a mid-level provider. Section 203(h) defines nurse practitioners' scope of practice as based on "educational preparation and the accepted scope of professional practice of the particular specialty area."¹⁸⁶ However, the section goes on to state that nurse practitioners activities should be performed "in collaboration with physicians and other health care professions and agencies."¹⁸⁷ Unlike the Nursing Practice Act, the proposed Health Assistant Practice Act should not include this kind of limitation as physicians are not present at the outer island health centers.¹⁸⁸

In drafting the scope of practice of health assistants, the Nitijela should be careful to ensure that the scope can be easily understood by health assistants.¹⁸⁹ By linking the scope of practice of the health assistants to their education, such as the Nursing Practice Act does for nurse practitioners, it may create confusion for health assistants who are many years removed from their initial training.

Instead, the Health Assistance Practice Act could define the scope of practice of health assistants based on disease type. An example of this type of regulation has been enacted in Kenya.¹⁹⁰ Like the Marshall Islands, Kenya is a developing country with an extreme physician shortage.¹⁹¹ To address its shortage, Kenya created a mid-level category of providers known as clinical officers.¹⁹² Kenya's Clinical Officers (Licensing, Training, and Registration) Act defines the scope of practice of its private practice clinical officers.¹⁹³ This law creates two lists of ailments that clinical officers are allowed to treat.¹⁹⁴ The first list consists of injuries, diseases, or illnesses that clinical officers are authorized to treat fully.¹⁹⁵ The second list includes injuries, diseases, or illnesses that clinical officers can stabilize but then must refer to a physician for additional treatment.¹⁹⁶ Almost all illnesses,

¹⁸⁶ Nursing Practice Act, 19 M.I.R.C. c. 2, § 203(h) (1995) (Marsh. Is.).

¹⁸⁷ *Id.*

¹⁸⁸ See Keni, *supra* note 13, § 1.

¹⁸⁹ See WHO, *supra* note 8, at 16 (stating that scope of practice regulations for mid-level providers should be clearly defined).

¹⁹⁰ See Clinical Officers (Training, Registration and Licensing) Act, (1989) 1st Schedule-4th Schedules (Kenya).

¹⁹¹ See Wilson, *supra* note 5.

¹⁹² See Mullan & Frehywot, *supra* note 7, at 2159.

¹⁹³ See Clinical Officers (Training, Registration and Licensing) Act, (1989) Cap. 260 § 13 (Kenya).

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* § 13(1).

¹⁹⁶ *Id.* § 13(5).

injuries and diseases are included in this second list. This second list allows clinical officers legal protection when they must treat an individual in an emergency situation, such as in the hypothetical at the beginning of this Comment, but also clearly communicates to these providers that they must transfer the patient as soon as he or she stabilizes. By enumerating the diseases, illnesses, and injuries that health assistants can treat independently and those which health assistants can treat only in emergencies, the Marshall Islands would satisfy the WHO recommendation of clearly defining the scope of practice of mid-level providers.

To ensure that the health assistants' scope of practice can be adjusted in the future, the Health Assistant Practice Act should grant the health assistant licensure board and the Ministry of Health the power to amend health assistants' scope of practice.¹⁹⁷ With this power, the health assistant licensure board could continuously examine health outcome comparisons between physicians and health assistants and then adjust their scope of practice accordingly.

3. *The Health Assistant Practice Act Should Require Health Assistant Candidates to Complete the Governmental Training Program and Annual Continuing Education Courses*

The Health Assistant Practice Act should grant the health assistant licensure board the power to determine the education requirements of health assistants.¹⁹⁸ Currently, health assistants practicing in the Marshall Islands are trained at the Marshall Islands Health' Assistant Training Program.¹⁹⁹ However, the shortage of health assistants during the 2004 budget shortfall²⁰⁰ indicates that in the future the Marshall Islands may have to hire mid-level providers from other countries if the government training program cannot keep pace with the Marshall Islands' growing population.²⁰¹ Consequently, the Health Assistant Practice Act could specify the Health Assistant Training Program as one acceptable training program, but should also grant the health assistant licensure board the power to specify other acceptable training programs. This provision would satisfy the WHO recommendation of clearly defining initial education requirements.

¹⁹⁷ See, e.g., Clinical Officers (Training, Registration and Licensing) Act, (1989) Cap. 260 § 16 (Kenya).

¹⁹⁸ See WHO, *supra* note 8, at 16.

¹⁹⁹ See Keni, *supra* note 13, § 2.

²⁰⁰ See Gootnick Letter, *supra* note 21, at 46.

²⁰¹ The Marshall Islands population is expected to double by 2020. WHO, *supra* note 105.

Beyond requiring health assistants to complete the governmental training program, the Health Assistant Practice Act should also require health assistants to complete annual or biannual continuing education courses.²⁰² Studies indicate the mid-level providers begin to lose knowledge learned during their training as soon as one year after graduation.²⁰³ To prevent this loss of knowledge, the Ministry of Health should require continuing education classes. Currently the Marshall Islands health assistants are not required to complete any continuing education courses.²⁰⁴ Continuing education programs for health assistants could be provided in multiple ways, including sending physician consultants to the outer island health centers or by requiring health assistants to travel to Majuro to complete refresher courses.²⁰⁵ By adding a continuing education requirement in the Health Assistant Practice Act, the Marshall Islands would ensure that its health assistants continue to develop clinical skills over the years. Such a requirement would also ensure that health assistants are adequately trained to provide other clinical services that are added to their scope of practice in the future.

4. *The Health Assistant Practice Act Should Define the Autonomy of Practice of Health Assistants and Should Take the Physician Shortage into Account*

The WHO also recommends clearly defining mid-level providers' degree of autonomy.²⁰⁶ Unfortunately, the Nitijela will not be able to model the degree of autonomy of health assistants on the Nursing Practice Act. The Nursing Practice Act states that nurse practitioners and licensed practical nurses must operate under the direction of a physician.²⁰⁷ Since health assistants work in remote island health centers without physicians,²⁰⁸ the Nitijela may decide not to limit the autonomy of health assistants at all. By clearly defining the scope of practice of health assistants, the Nitijela could ensure that more complex cases are referred to physicians. However, if the Ministry of Health is considering utilizing health assistants in the Majuro hospital it could add another list to the health assistant scope of

²⁰² See WHO, *supra* note 8, at 17.

²⁰³ See Ofori-Adjei & Arhinful, *supra* note 168, at 1169.

²⁰⁴ See Health Services Act, 19 M.I.R.C. 1, § 112 (1983) (Marsh. Is.). The Health Services Act mandates that the Department of Health Services offer continuing education programs when appropriate but does not require health care providers to attend these programs to renew their licenses.

²⁰⁵ See Keni, *supra* note 13, § 7.

²⁰⁶ See WHO, *supra* note 8, at 16.

²⁰⁷ Nursing Practice Act, 19 M.I.R.C. c. 2, § 203 (1995) (Marsh. Is.).

²⁰⁸ See Keni, *supra* note 13, § 1.

practice section that includes procedures and illnesses that health assistants can treat under the supervision of physicians.

5. *The Health Assistant Licensure Board Should Have Disciplinary Powers Similar to the Board of Nurse Examiners*

Finally, to ensure that mid-level providers comply with these regulations, the WHO also recommends creating clear accountability mechanisms.²⁰⁹ The disciplinary powers of the health assistant licensure board should be modeled on section 233 of the Nursing Practice Act. This section grants the Board of Nurse Examiners the authority “to refuse to issue or renew, to suspend, revoke, restrict, place on condition, place on probation or reprimand a license.”²¹⁰ The board can use this authority if it determines that a license holder has been convicted of a crime, violated his or her scope of practice, or in some other way failed to meet the responsibilities of his or her license.²¹¹ Section 233 also grants the board the authority to fine the individual for up to fifty percent of the cost of board’s proceedings.²¹²

These accountability mechanisms should be consistent with the Marshall Islands Administrative Procedures Act. The Nursing Practice Act states that the disciplinary procedure established by the licensing board should be consistent with the Administrative Procedures Act.²¹³ The Administrative Procedures Act establishes guidelines for administrative hearings in the Marshall Islands.²¹⁴ To ensure fairness in the disciplinary process, the Health Assistant Practice Act should require the health assistant licensure board to comply with the Administrative Procedures Act.

V. IMPENDING AID REDUCTIONS MAY IMPROVE THE POLITICAL FEASIBILITY OF ENACTING THE HEALTH ASSISTANT PRACTICE ACT

Two groups of providers may oppose enacting a comprehensive health assistant licensure scheme: physicians groups and the health assistants themselves. As previously discussed,²¹⁵ professional competition has led physician associations in many countries to oppose the recognition of mid-level providers.²¹⁶ To ensure that the Health Assistant Practice Act is passed,

²⁰⁹ See WHO, *supra* note 8, at 16.

²¹⁰ Nursing Practice Act, 19 M.I.R.C. c. 2, § 233 (1995) (Marsh. Is.).

²¹¹ *Id.* § 233(b).

²¹² *Id.* § 233(a).

²¹³ *Id.* § 234.

²¹⁴ Marshall Islands Administrative Procedure Act, 6 M.I.R.C. c. 1 (1979) (Marsh. Is.).

²¹⁵ See *supra* Part II.C.2.

²¹⁶ See Dovlo, *supra* note 28, at 8.

the Ministry of Health should engage physicians in the Marshall Islands in the drafting process. In some countries, initial “[c]oncerns by professional groups about potential loss of earnings are dissipated by the benefits of reduced workloads and increased time for higher professional demand.”²¹⁷ Consequently, educating physicians about the benefits of burden shifting will be essential.

In addition to physician groups, the health assistants may oppose this new law because it would increase their obligations with respect to continuing education and could potentially restrict their current scope of practice. However, as previously discussed, continuing education²¹⁸ and limited scopes of practice²¹⁹ are critical to ensuring that mid-level providers are adequately trained for their clinical roles. Consequently, the Nitijela should continue to pursue this law even if opposed by the health assistants.

Despite this opposition, the impending reductions in international aid from the United States²²⁰ may motivate physician groups and the health assistants to accept the enactment of a health assistant licensure law. Based on past evidence of budget shortfalls,²²¹ any decreases in the health budget could increase the burden placed on both health assistants and remaining physicians. In light of this potential burden increase, health assistants may be more inclined to support the law to limit the services that could be shifted to the outer island health centers. Similarly, physicians may be more inclined to support the law in order to identify certain simpler tasks that could be shifted to health assistants allowing physicians to focus on more complex cases. Thus, the Marshall Islands should immediately engage both physicians and health assistants in drafting the Health Assistant Practice Act before the aid reductions begin to significantly undermine the Marshall Islands’ health care budget.

VI. CONCLUSION

Given the slow progress towards the health MDGs, many countries are increasing the number and expanding the role of mid-level health care providers. As the roles of these providers evolve, governments should review their mid-level licensure laws to ensure that their licensure provisions clearly and appropriately define mid-level providers’ scope of practice and require sufficient training for their evolving clinical roles. This is especially

²¹⁷ *Id.*

²¹⁸ See WHO, *supra* note 8, at 17.

²¹⁹ See *id.* at 16.

²²⁰ See Gootnick Letter, *supra* note 20, at 1.

²²¹ *Id.* at 45.

necessary in countries with few mid-level provider licensure regulations, such as the Marshall Islands.

The scenario at the beginning of this Comment illustrates the difficult treatment decisions that can be faced by Marshall Islands' health assistants. As international aid from the United States decreases in the coming years and the outer island communication and triage system likely deteriorates, the complexity of these decisions will likely only increase. To ensure that health assistants are adequately prepared for these situations, providers and policy makers will need to come together to enact a comprehensive health assistant licensure scheme that acknowledges both the critical importance and immense challenges of providing quality health care on these remote Pacific atolls.