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Posted Date: 13 May 2024

doi: 10.20944/preprints202405.0837.v1

Keywords: Physician Associate; Physician Assistant; Comparative Healthcare Policy Analysis

 doi:10.20944/preprints202405.0837.v1



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# What Can Policy-Makers in the United Kingdom Learn from the Regulation of Physician Assistants in the United States of America?

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**Abstract:** The role of Physician Assistant emerged in 1960s America and their number has increased to become a significant component of the health care workforce in that country. On the eve of a new policy regulating Physician Associates in the United Kingdom, the role of key actors in shaping the development of regulatory policies in the two countries is critically compared against a backdrop of very different political contexts and health care systems, to reveal the factors that might help or hinder the deployment of Physician Associates/Assistants and ameliorate workforce shortages.

**Keywords:** physician associate; physician assistant; comparative healthcare policy analysis

## Introduction

The World Health Organization (WHO, 2020) estimates there will be a global shortage of 10 million healthcare workers by 2030. One way of addressing this is to enable the existing workforce to take on extended roles (Blank, Burau and Kuhlmann, 2017). In the 1960s the Physician Assistant role was introduced by Dr. Eugene Stead, to mitigate the shortage of primary care doctors in rural America (Cawley, Cawthon and Hooker, 2012). Drawing from his experience of rapidly training medics during World War II, Dr. Stead developed a model to facilitate training of non-medical healthcare workers who could transition into the new role of Physician Assistant. The aim was that an accelerated medical training package would enable these individuals to safely assess, diagnose and provide treatment for patients in primary care, under the direct supervision of a doctor (Hooker, Cawley and Everett, 2017).

Since the 1960s the role of Physician's Assistant, or Physician's Associate (PA), has been adopted in eighteen countries including the United Kingdom (UK), Liberia, India, Ghana and the Netherlands (Jiang et al., 2022); Poland was the latest to introduce PA training, in 2019. There is, however, considerable variation in the training, professional autonomy and number of PAs in each country, as summarised below.

## Training of PAs

The majority of PA training programmes take between two and four years, and tend to be at postgraduate or masters level (Pasquini, 2018). Often, access to PA courses is limited to qualified healthcare professionals, although some countries such as Ghana have widened entry requirements to include school leavers in order to facilitate growth of the profession (Adjase, 2015).

## Professional Autonomy of PAs

The scope of practice and professional autonomy of PAs varies from country to country due to differences in healthcare systems, regulatory frameworks, and professional standards. In some countries such as the Netherlands, PAs are able to prescribe medications and work autonomously, diagnosing and treating conditions without direct medical supervision (van Doorn–Klomberg,

 doi:10.20944/preprints202405.0837.v1



Ruiterkamp and van den Brink, 2022). In others, such as the UK, PAs work directly under the supervision of doctors and are unable to prescribe medicines (Howie, Howie and Seville, 2023).

**Number of PAs**

A global PA census in 2020 established that there were 132,526 PAs, with 120,000 of these employed in the United States (Hooker and Berkowitz, 2020). There was seemingly no correlation between the length of time since the introduction of the PA model within a country and the number of PAs. For example, both Germany and the UK introduced PA training programmes within a year of each other, but the UK had twice the number of PAs at the time of the census.

The following analysis will investigate healthcare policy across two countries: the US and the UK. These countries have been chosen to provide a contrast of contexts (e.g., differing healthcare systems, political influences, societal factors) within which the PA role has been developed. The analysis will conclude by examining the implications for practice in the UK, where regulation is due to occur in 2024.

There is a variant on the PA role in the UK; Anaesthetic Associates are a separate profession trained to provide anaesthetic and perioperative care. As their numbers are still small (according to the Royal College of Anaesthetists [2024] there are currently 182 in the UK) and there is no equivalent in the US, they are not included in this analysis.

**Aim**

To conduct a comparative policy analysis of the factors influencing the agenda-setting for regulation of physician associates (PAs) in the United States (US) and the United Kingdom (UK).

**Objectives**

1. To use the Multiple Streams Approach (Kingdon, 2010) as a framework to consider the problems, policies and politics which impact regulation of PAs, in the US and the UK.
2. To review the literature on which healthcare policy regarding regulation of PAs in the US and the UK is based.
3. To consider the impact of the regulation of PAs on professional practice and service development in the UK.

**Methodology**

*Comparative Strategy*

Ragin (2014) differentiated between variable-oriented and case-oriented comparative analysis, where the former focuses on establishing relationships between variables, often drawn from a sizable sample size, while the latter emphasises a more in-depth examination of a smaller number of cases. This analysis will take a qualitative case-oriented approach to seek to understand the complex factors influencing the regulation of PAs.

*Selection of Countries*

Two countries have been selected to allow for both breadth and depth of analysis. The selection of the UK is based on the pending regulation of PAs, set to take place in 2024, whilst the US has been selected as the country with by far the largest number of PAs and a history of supportive policy development spanning fifty years.

*Conceptual Framework*

This analysis will focus specifically on one facet of the policy process, agenda-setting This focus has been chosen to facilitate a direct comparison between the UK, where policy development in this

 doi:10.20944/preprints202405.0837.v1



area is still in the early stages of development, and the US, where policy development is more advanced.The Multiple Streams Approach (MSA) will be used, as the framework most commonly associated with this aspect of policymaking (Cairney and Zahariadis, 2016). The MSA proposes that there are three separate processes or streams: problem, policy and politics (Kingdon, 2010). At times these may come together, with input from policy entrepreneurs, to form a window of opportunity allowing for a particular issue to be added to the policy agenda.

**Problem Stream**

Kingdon (2010) contended that within any system there exist numerous conditions that may not necessarily be perceived as a priority by policymakers, e.g., poverty, health, education. For an issue to progress to the stage where action is deemed necessary, it must be recognised as a problem rather than merely a condition. Thus, we begin by exploring how lack of regulation of PAs came to be defined as a problem, within the US and the UK.

*From Condition to Problem*

The inaugural cohort of US PAs completed their training in 1967 and four years later, in 1971, the role received a significant boost when Congress allocated $4 million to support the development of PA educational programmes (Hooker and Cawley, 2020). This led to a rapid increase in PAs, and subsequent debate about whether regulation was required; on one hand it was argued that regulation would put in place a process whereby physicians could formally delegate tasks to PAs and therefore make better use of medics' time (Physician Assistant Board, 2024), on the other it was contended that regulation would limit the flexibility of the PA/Physician relationship (Adamson, 1971).

Regulation of healthcare professionals in the US occurs at state rather than federal level (Hollings and Pike-Nase, 1997). Consequently, regulation progressed at varying rates across the country By 1972, nearly half the states had passed PA legislation of some kind, indicating that regulation was an issue worthy of policymaker attention (Dean, 1973). Whilst some of the legislation pertained to general delegatory statute (enabling physicians to delegate to PAs), eighteen states had passed legislation approving a regulatory authority (a state agency to oversee PA training and practice). Over the following decades the number of PAs increased from 3700 in 1975, to 40,000 in 2000 (Larson and Hart, 2007) and then to 120,000 in 2020 (Hooker and Berkowitz, 2020). During the 1980s and 1990s, the American Academy of PAs (AAPA) argued for regulation to both protect the public and to define the scope of practice of PAs (AAPA, 2017), and in 2000 Mississippi became the final state to regulate PAs in the US (He, Cyran and Salling, 2009).

Thirteen US PAs were deployed to work in the UK as part of the first UK PA pilot project, in 2003 (Woodin et al., 2005). The pilot established that they were safe and clinically effective, but were hampered by lack of UK regulation which meant they were unable to utilise all their skills (e.g., prescribing). Following this pilot, four training programmes were established, leading to the introduction of UK-trained PAs in the NHS in 2005 (Straughton et al., 2022). Despite calls for regulation (e.g., Ross and Parle, 2008), there was limited momentum initially. It is likely that this was due at least in part to the slow growth of the profession in comparison to the US; in 2015 there were only approximately 200 PAs in the UK (Marchant, 2015). This aligns with the threshold model of problem identification which suggests that conditions are only defined as problems when they garner a critical mass of individuals who collectively perceive them as problematic (Dan Wood and Doan, 2003). The small number of PAs in the UK at this time may have diminished the perceived need for regulation, and policy-makers may have wished to allow different models of PA practice to emerge before formalising the role through policy and guidelines.

The number of PAs in the UK began to grow more rapidly in 2016, following an increase in Heath Education Commissioned training places from 205 to 657 per annum (HEE, 2016). The following year, the government further signalled their support for the PA role with a consultation into regulation of PAs (alongside other new professional roles) (DHSC, 2017), although the response to the consultation was not published until 2019 (DHSC, 2019).

 doi:10.20944/preprints202405.0837.v1



Regulation gathered pace in the UK following two precipitating incidents, or 'focusing events' in Kingdon's terminology. In 2022, an investigative journalist, operating covertly as a receptionist within a private network of GP surgeries, revealed that patients were receiving care from inadequately supported PAs instead of GPs, raising concerns regarding patient safety (Wakefield, 2022). Then, in 2023, it was reported that a patient had died following misdiagnosis by a PA (Jones, 2023). These events had the impact of shifting the public perception of PA regulation from a condition to a problem. This can be seen as an example of what Baumgartner, Jones and Mortensen (2018) refer to as punctuated equilibrium, wherein slow, incremental development is supplanted by a need for rapid change.

*Problem Brokers*

It has been argued that adding the concept of agency, specifically a *problem broker*, would enhance the MSA problem stream (Knaggård, 2015). This is an actor that defines the problem, explains why it is of concern and emphasises to policymakers the need for prioritisation. In the US, the American Medical Association backed the case for PA regulation from as early as 1971 (AAPA, 2017) and their support was critical to the successful growth of the profession. At this point the medical profession still maintained significant influence over policymakers, and their perspectives were both sought after and trusted (Freidson, 1985); medical authority was to see a decline in the US over the following decades (Milbank, 2002). It is important to consider the timing of the intervention by the AMA; the 1970s and 1980s marked a notable decrease in medical authority (Schlesinger, 2002), and it is doubtful that the AMA would have wielded the same influence as a problem broker a decade later.

In the UK, the Faculty of Physician Associates (FPA) has attempted, over several years, to fulfil the role of problem broker. Established in 2015, the FPA is responsible for managing the voluntary register of PAs and setting education standards. The FPA has campaigned consistently for PA regulation, as did its predecessor, the UK Association for Physician Associates (UKAPA) (Rimmer, 2014). They argue that regulation would empower PAs to practise more effectively by allowing them to perform tasks like prescribing (FPA, 2022a). It is noteworthy that even though it has been 18 years since the UKAPA first raised the issue, regulation has still not been implemented, indicating that the campaigning has not had the desired impact.

The campaigning outlined above is an example of what Schön and Rein (1994) describe as framing; they argue that narratives or frames are used to interpret reality, in order to provide policymakers with guideposts for action. The UKAPA and later the FPA framed regulation of PAs as being concerned with effective use of the PA workforce. However, it was not until the negative publicity of 2022/2023, and a reframing of the need for regulation, that policymakers started to pay attention. Several new problem brokers contributed to the process, and their argument was based on the requirement for patient safety via regulation, as opposed to benefit to the profession espoused by the FPA. These included an MP, Barbara Keely, who called in parliament for regulation of PAs on patient safety grounds following the death of a constituent following misdiagnosis by a PA (Hansard HC Deb, 6 July 2023). Several doctors' organisations also joined the call for PA regulation to ensure patient safety, including the British Medical Association (BMA, 2023a) and the Doctors Association (DAUK, 2023). The arguments of these newer problem brokers appear to have had much more of an impact on problem identification by policymakers than years of campaigning by the FPA.

**Politics Stream**

Kingdon (2010) states that the judgement of policymakers is generally shaped by factors such as the national mood and the influence of interest groups. Discussions about the regulation of PAs in the US and UK took place in very different contexts, as will be described in the next section of this analysis.

 doi:10.20944/preprints202405.0837.v1



*United States in the 1960s*

The introduction of PAs in the US, along with the initiation of regulatory measures in certain states, occurred shortly after what was arguably the most significant healthcare policy reform in American history—the establishment of Medicare and Medicaid in 1965. The former provided federal health insurance for everyone over the age of 65 (and some younger people with certain disabilities) and the latter gave health coverage to people on a limited income (Falk, 1973). Whilst the reforms were very popular with the public (Brodie, Hamel and Norton, 2015), the American Medical Association strongly opposed them citing loss of freedom and patient choice (Cohen, 1985). Prior to Medicare and Medicaid there had been concern about physician shortages (US News, 2015). After the reforms, these concerns intensified as there was a significant increase in both accessibility to healthcare and the associated costs (DeWalt et al., 2005).

The likelihood of task-shifting from doctors to other healthcare professionals increases under pressure on health systems (Maier and Aiken, 2016; Lamberti-Castronuovo et al., 2022), and this was indeed evident in the US during the late 1960s. The PA role was launched at an opportune time, providing an innovative solution to the physician shortages at a reduced cost. Additionally, there was an available workforce as veterans with medical training returned from the Vietnam War, leading to a focused initiative to retrain them as PAs to ensure that their skills were utilised (Brock et al., 2013).

Initially there was some opposition to the PA role and to aspects of their regulation. Notably, the American Nursing Association was highly critical of the profession when it was first introduced and, in particular, the suggestion that the new PA workforce could be drawn in part from the nursing profession (Holt, 1998). There was also unease about how PAs fit into the medical hierarchy, with a contentious article entitled "More than a nurse, less than a doctor" causing significant debate when it was published in 1970 (Carter and Ballweg, 2017). However, the medical community as represented by the American Medical Association (AMA) embraced the new role and supported its regulation (Cawley, Cawthon and Hooker, 2012). Although their power was set to decline over the coming decades, doctors still carried significant authority in the US in the 1960s (Hafferty and Light, 1995), and as such their support of PAs had greater weight than that of some critics. It is interesting to note that doctors have in the past resisted the advancement of healthcare professionals (Sox , Ginsburg and Scott, 1995), perhaps fearing a decline in medical dominance. In the case of PAs, their direct supervision by doctors meant that there was no loss of power to the medical profession therefore PAs were perhaps a less threatening concept to physicians than some of the other newer professions.

*United Kingdom in the 2020s*

Although the British public has been consistently supportive of having a National Health Service since its foundation, the impact of the COVID-19 pandemic has led to a significant decline in satisfaction according to the most recent British Social Attitudes survey (NatCen, 2023). Cited reasons for this include the length of time to get a GP appointment and lack of NHS staff. The UK government has attempted to address concerns about workforce shortages with their NHS Long Term Workforce Plan (NHS England, 2023), which includes the recruitment and regulation of PAs. They initially consulted on regulation of PAs in 2017 and the feedback was overwhelmingly positive, with 95% of respondents indicating a preference for it (DHSC, 2019). There was less unanimity regarding the appropriate regulator; 59% advocated for the General Medical Council (GMC) which regulates doctors, 20% for the Health and Care Professions Council (HCPC) which regulates Allied Health Professionals, while the remaining respondents either expressed indifference, did not respond, or proposed an alternative regulator. However, the response of the British Medical Association (BMA) was unequivocal on this matter – they argued that as PAs were not medics, they should not come under the medical regulator but should instead be regulated by the HCPC (BMA, 2017).

The government chose to disregard the concerns of the BMA and asked the GMC to regulate PAs in 2019 (GMC, 2023). Traditionally in the UK, the state has acceded power to medics on constitutional matters (Day and Klein, 1992) such as the regulation of healthcare professionals, and it is noteworthy that they chose not to do so on this occasion. This compelled the BMA to turn to

 doi:10.20944/preprints202405.0837.v1



lobbying and public relations tactics, a recourse previously taken by them during conflict with the government on the NHS reforms of the 1980s (O'Neill, 1998). Their campaigning has become increasingly belligerent and has included calls for a halt to PA recruitment until the issue of who regulates them has been resolved (BMA, 2023a), encouraging members to lobby their MPs (BMA, 2023b), and publicising a BMA-commissioned survey which established that 87% of doctors had patient safety concerns about PAs (Foster, 2023). There has been extensive debate on Twitter/X, with one commentator characterising a hostile narrative emerging from doctors towards PAs on social media (Oliver, 2023). In the wake of this, PAs have described feeling victimised by some of their medical colleagues (Glen, 2023, Gowland, 2023), as they await long-sought regulation.

The PA profession is not currently widely known about or understood by the UK public. A recent survey found that 57% of respondents had never heard of them, whilst 25% believed the title referred to a doctor (Campbell, 2023). This is relatively unsurprising, given that the public commonly perceives the NHS as primarily composed of doctors and nurses (El-Awaisi et al., 2020), overlooking the significant contribution of the remaining two thirds of staff who play a crucial role in running the service (Rolewicz, Palmer and Labont, 2022). It is also important to note that the profession is still relatively small and thinly spread across the UK; a recent census reported that most counties employed fewer than 50 PAs each (FPA, 2022b).

**Policy Stream**

According to Kingdon (2010), the policy stream is where solutions take shape, emerging from a "primeval soup" of potential policies. He went on to outline a process whereby proposed policies undergo a process of evolution, including elements such as ensuring public acceptability, technical feasibility, value acceptability and resource adequacy. This process is often facilitated by *policy entrepreneurs*; these are individuals or organisations who may incorporate elements of the problem broker role discussed earlier in this analysis, but importantly go beyond this by actively advocating for policies aimed at addressing identified problems (Arslangulov and Ackrill, 2022).

The following section will examine how proposed policies relating to the regulation of PAs evolved in both the US and the UK. The focus will be on two elements of the process, public acceptability and technical feasibility, as there has been significant divergence between the two countries in how these aspects have impacted on policy development.

*Public Acceptability*

Involving stakeholders in policy development provides legitimacy (Masefield et al., 2021) and increases the likelihood of acceptance upon implementation (Petkovic et al., 2020). Although the governments in both the US and the UK actively promoted stakeholder feedback on PA regulation, their approach differed. Stewart (2009) argues that stakeholder engagement can be viewed on a continuum, ranging from information-giving or consultation (with minimal stakeholder participation) to participatory governance or delegation (with significant stakeholder participation). As will be seen, the stakeholder engagement in the US was far more participatory in nature than that conducted in the UK, leading to very different outcomes.

Regulation of healthcare professionals in the US is at state level, although the federal government may influence this in a variety of ways (Leslie et al., 2021). For example, regulation of PAs received active support from the federal government in 1969, who granted a contract to Duke University (where the first PA programme had recently started) to formulate a licensure model adaptable for use by individual states (Davis et al., 2015). To develop this, the University sought input from a diverse range of stakeholders, including legal, educational, and healthcare professionals, as well as PAs and physicians. The model to support the new legislation included role flexibility, prioritisation of patient safety, and the importance of a scope of practice overseen by a physician (Estes and Carter, 2005).

The development of the licensure model proved to be a sound strategic decision. In the US, changes to state law require sponsorship by a *representative* who champions the cause. Duke University took on the role of policy entrepreneur, providing representatives with a ready-made

 doi:10.20944/preprints202405.0837.v1



solution to the issue of PA regulation, crafted with significant input from stakeholders to guarantee widespread acceptability.

The UK government has also engaged stakeholders with the regulation of PAs, undertaking three public consultations on different elements of regulation over the course of six years (DHSC, 2023). The requirement for consultation is embedded in UK legislation; a three-month public consultation is mandated whenever there is a modification to the regulation of a healthcare profession (Health Act, 1999) to ensure stakeholder acceptability. As discussed earlier, whilst the need for regulation of PAs has not been disputed by stakeholders, the choice of regulator has been strongly contested. The UK government has so far chosen to disregard this element of the consultation feedback, designating the GMC as regulator and assigning them responsibility for formulating a regulatory framework for PAs (DHSC, 2023). It is anticipated that this will be a contentious process, given that a substantial portion of GMC registrants oppose their role as the PA regulator.

Choi and Wong (2023) outline strategies employed by administrations to divert attention from consultation responses they find unfavourable: "non-commitment, case closure, disengagement for irrelevance, and placation" (pp. 1). The UK government appear to be employing the first of these, non-commitment, as they have not provided any response to the BMA's calls for alternative regulators to be considered but have simply ignored it. A counterstrategy to non-commitment is *network mobilisation*, where other stakeholders are rallied to the cause (Choi and Wong, 2023), a tactic evident in the ongoing campaign led by the BMA.

It is not entirely clear who is taking on the role of Policy Entrepreneur for PA regulation in the UK. NHS England and the Department for Health and Social Care have both contributed to this by publishing documents supporting regulation (DHSC, 2023; NHS England, 2023), however in this context both organisations lack some of the key elements of policy entrepreneurship described by Mintrom (2019). These include collaborating with advocacy coalitions and expanding networks; as described above PA regulation in the UK largely appears to be operating in a vacuum. Lack of Policy Entrepreneurs has hampered policymaking in other settings, even where all other elements of the Multiple Streams Approach align (Schumacher, 2022), and this is therefore of concern when it comes to PA regulation.

*Technical Feasibility*

Kingdon (2010) emphasised the importance of technical feasibility i.e., ensuring that the policy can be delivered within the existing resources. The regulation of PAs is part of the broader domain of healthcare regulation. Consequently, it is imperative that the latter is operating effectively to facilitate the implementation of PA regulation. This is not the case in the UK where there have been calls for regulatory reform over many years, prompted by a series of highly critical reports. These found confusion caused by the overlap of functions between different regulators (Francis, 2013), and mistrust between registrants and regulators which led healthcare professionals to be guarded in their dealings with regulators (PSA, 2018, Williams, 2018). The regulation of a new profession, PAs, was not feasible until regulatory reform had addressed these issues.

The need for reform was underscored by the COVID-19 pandemic which highlighted additional issues, revealing instances where regulators were unable to add temporary registrants to assist with the health emergency or to amend their rules to enable remote hearings (DHSC, 2023). This compelled policymakers to address the longstanding issue of regulatory reform, with PAs being the first profession to be directly impacted by the new legislation.

One of the challenges of the UK regulatory system for healthcare professionals is its complexity, with nine national statutory organisations which regulate different groups of staff. Some only have responsibility for one profession, such as the General Medical Council (GMC) who regulate doctors, whilst others such as the Health and Care Professions Council regulate fifteen different professions (NHS Employers, 2022). Currently, all regulators have very different powers and function in distinct ways. In 2021, the government unveiled a regulatory reform plan aimed at simplifying legislation, granting similar powers to all regulators, and enhancing their autonomy (DHSC, 2023). With these reforms underway, the legislation for the regulation of PAs can now proceed. To this end, the

 doi:10.20944/preprints202405.0837.v1



Anaesthesia Associates and Physician Associates Order was laid before parliament in December 2023 (Parliament. House of Commons, 2023), with plans for regulation to be implemented by the end of 2024 (GMC, 2023).

Alongside the primary legislation outlined above, there are a further twenty-three other pieces of UK legislation which need to be amended for PA regulation to be properly supported (DHSC, 2023). These include pieces of legislation which define how health professionals practise (e.g., Human Medicines Regulations 2012), their governance systems (e.g., Medical Act 1983) and how they are reimbursed (e.g., Income Tax Act 2003). This all adds further complexity to the regulation of PAs in the UK.

The technical feasibility of PA regulation in the US is also challenging, but for different reasons than the UK. Despite the licensure model proposed by Duke University in the 1970s, significant differences in PA licensure now exist across individual US states, creating a complex landscape and substantial variation in the time required for PAs to secure licenses when relocating between states. In most jurisdictions PAs are approved through the state medical licensing board, although some states have set up separate PA licensing boards for this purpose (AMA, 2018). As well as meeting the licensure conditions of the individual state, most licensing boards will also make additional requirements including conducting interviews with PAs, jurisprudence examinations and submission of letters of recommendation (NNCPA, 2018). These extra conditions mean that in some states, PAs are having to wait up to 16 weeks to secure their license to practice (Miller, 2018), leading to delays in patient treatment.

A solution to the licensing delays, backed by federal funding and crafted collaboratively by stakeholders including the American Academy of PAs and the National Commission for the Certification of PAs, involves the establishment of PA Compacts (Council of State Governments, 2023). These enable PAs to hold licenses that permit practise across any state which has a Compact agreement in place. Currently, this applies to three states, whilst a further twelve have started the process (PA Compact, 2024). The legislation is set to become operational once it has been fully implemented by seven states, a development expected to occur imminently.

**Window of Opportunity**

Kingdon (2010) proposed that windows of opportunity may open either due to focussing events such as crises, or during periods of institutionalised change such as elections. In both the US and the UK, focusing events led to the window of opportunity for PA regulation. Kingdon (2010) proceeded to emphasise that these windows are transient, and the focus of policymakers can swiftly shift elsewhere.

In the US, regulation of PAs has been in place across all states for over two decades now, and although there are some challenges as discussed above, these relate to fine-tuning of the policy. However, the UK is poised at a critical juncture; whilst PA regulation is scheduled for 2024, there remains significant opposition. The Statutory Instrument (SI) which allows the GMC to regulate PAs was debated and passed by the delegated legislative committee on 17th January 2024 (Draft Anaesthesia Associates and Physician Associates Order, 2024). There have been concerns expressed about use of SIs for such a controversial issue - theoretically they should only be used for technical updates due to their relative lack of scrutiny in comparison to other legal mechanisms (Green, 2020). The order was later approved by the House of Lords on 26th February 2024, following a 2 ½ hour debate (Hansard, 2024). The Doctor's Association have said that they are seeking to legally challenge this legislation (Colvicchi and Lind, 2024), meaning that the window of opportunity may close before the policy can be implemented. This would have significant implications for professional practice as will now be explored.

**Implications for Professional Practice**

In the US, PAs have evolved into an integral component of the healthcare system, with their role encompassing the authority to prescribe in most states, alongside a broad scope of practice. Regulation has served its purpose of protecting the public, providing confidence in the profession,

 doi:10.20944/preprints202405.0837.v1



and allowing for standards to be set (DHSC, 2023). The following section of this analysis will examine each of these elements, in relation to the professional practice of PAs in the UK.

*Public Protection*

One of the strongest arguments that has been made by supporters from both sides of the ongoing UK regulation debate is that PA regulation will protect the public. There is a voluntary PA register, set up and managed by the Faculty of Physician Associates (Saunders, 2023), however it is not clear what percentage of qualified and practicing PAs are on this register. Although employers are advised to check that a PA is on the register before employing them (CQC, 2022), this is not a mandatory requirement. It is therefore possible for a PA to practise without being on the register in a way that would not be possible with regulated healthcare professionals. This in turn means that there is potential for a PA to have a history of unsafe work practises, and to operate without supervision or the necessary skills, and yet still retain employment as a PA.

*Confidence in the Profession*

Much criticism levelled at PAs recently stems from lack of confidence in their professional capabilities (Jackson, Marshall and Schofield, 2017). Regulation would address this by ensuring that all registrants are competent and fit to practice, through a system of registration and revalidation.

*Standard Setting*

Regulation allows a regulator to establish standards that must be met for a registrant to retain their place on the register. These may include standards for education, professional practice, and conduct (NHS Employers, 2022). In the case of PAs, this would have two main impacts. Firstly, it may alleviate concerns about the public's lack of understanding regarding the distinction between PAs and doctors (BMA, 2023b). Although the Faculty of Physician Associates have issued professional guidance advising that PAs must explain what their role is (FPA, 2023), a regulatory requirement to do so would carry more weight. The second impact of regulatory standard setting is that it ensures consistency across the profession, paving the way for an expansion to the professional practice

In the short to medium term there are two major changes to practice which PA regulation would enable; prescribing medications and requesting ionising radiation (such as Chest Xray or CT Scans), both of which can legally only be undertaken by regulated healthcare practitioners (FPA, 2023). The former in particular would have a significant impact. Unless PAs can prescribe, they are unable to meet all the needs of their patients. This has led both PAs and those who work alongside them to express frustration at these limitations (Ritsema and Roberts, 2016; Jackson, Marshall and Schofield, 2017). Although this is downplayed by the Faculty of Physician Associates who say that PAs simply need to ask their supervisor to prescribe medication where needed (FPA, 2018), this additional step in the treatment pathway slows down the process. Currently some PAs are circumventing this by using their previous healthcare registration (e.g., nursing) to prescribe, subject to employer approval (GMC, 2024). However, with most PAs being drawn from prior roles unable to prescribe, such as healthcare assistants (FPA, 2022b), the number of PAs prescribing in this way is limited.

## Conclusions

This comparative policy analysis illustrates the effective application of the Multiple Streams Approach (Kingdon, 2010) to examine policy agenda-setting in relation to PA regulation. Both the UK and the US have been prompted to address this issue, driven by the worldwide healthcare staffing crisis and the imperative to devise innovative solutions. In the US, the PA role and subsequent regulation came at a time of significant public concern about lack of doctors following the Medicare and Medicaid reforms. Collaboration between the medical profession and policymakers was pivotal in driving regulatory change, contrasting starkly with the situation in the UK where policymakers appear to have largely disregarded the concerns expressed by the medical profession. This has led

 doi:10.20944/preprints202405.0837.v1



medical bodies in the UK to become increasingly vocal in their opposition to the regulatory proposals for PAs, lobbying parliament and running public campaigns.

The regulatory measures governing PAs in the US can be deemed successful, fostering the widespread acceptance and growth of the profession. PA regulation in the UK is poised to yield comparable impact, however for this to happen policymakers will need to learn from the US approach, where stakeholders were actively engaged in the process of regulation.

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