

# BEYOND MEDICAL LICENSURE

*Is licensing more important for doctors than for interior decorators or hair braiders?*

◆ BY SHIRLEY V. SVORNY

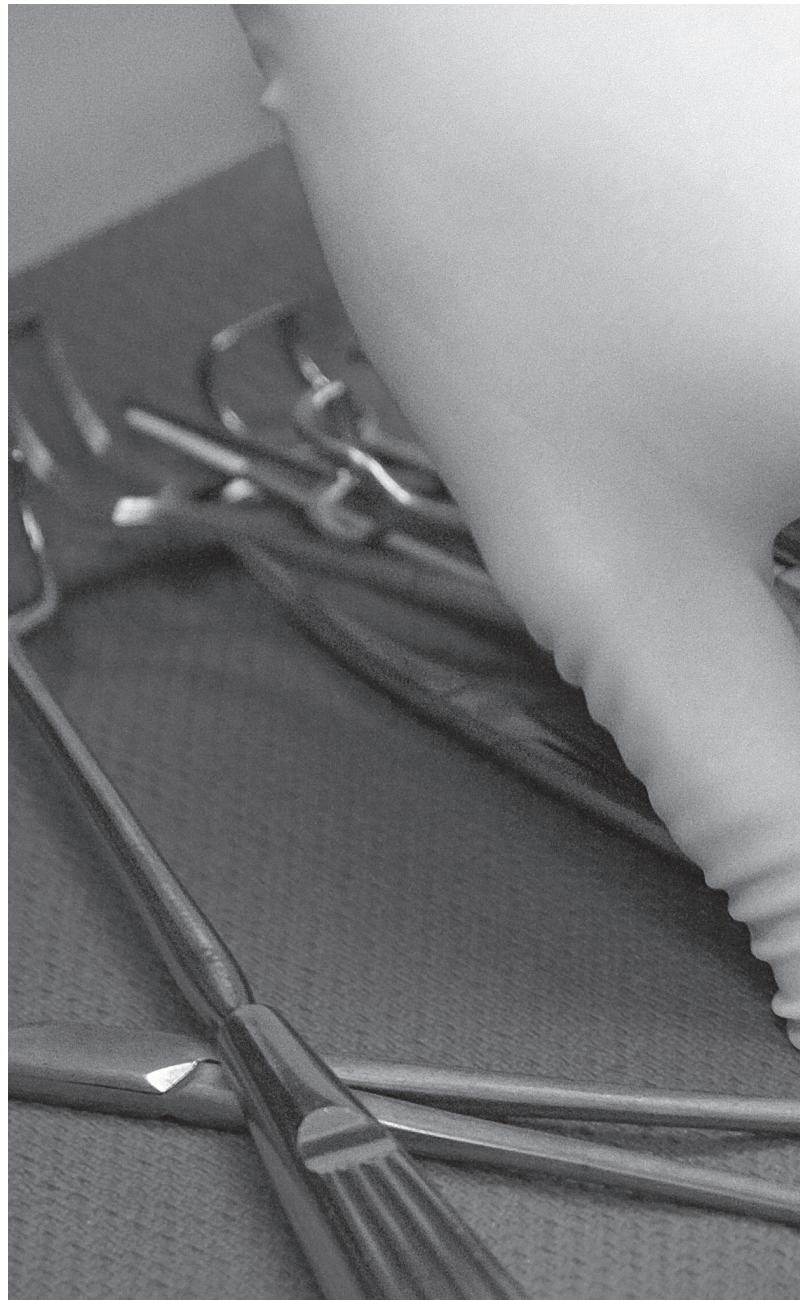
It is becoming common to read criticisms of state occupational licensing laws. The laws are a serious barrier to employment and business creation, and the problems with those barriers are increasingly appreciated by policymakers, the public, and the courts.

But when it comes to medical professionals, many of the staunchest critics of licensing back off. Though medical licensing boards display many of the same cartel-like behaviors as other licensed business groups, producing the same negative consequences for consumers, some otherwise vigorous critics of licensing make an exception for health professionals. Ignorance of patient protection mechanisms and the limitations and problems created by state licensing are to blame for this mistaken exception.

For example, when Texas Gov. Gregg Abbott (R) was running for office, his campaign released an “Occupational Licensing” position paper advocating an end to state licensing of interior designers and many other professionals. But the paper explicitly defends the licensing of physicians. Speaking on the future of U.S. health care reform, University of Chicago economist and Cato senior fellow John Cochrane argues for fewer regulations in health care markets, but he allows that licensure plays an important role in assuring physician quality. Lawyers Aaron Edlin and Rebecca Haw, in addressing the challenge to licensing in *North Carolina State Board of Dental Examiners v. FTC*, stress the similarities between actions of state licensing boards and private cartels. Yet they take the position that “for some professions, licensing provides such an obvious public benefit that barriers to entry and regulation of practice are accepted as necessary evils.”

Even the Federal Trade Commission, which has challenged the cartel-like behavior of licensing boards, has explicitly excluded health professionals in recent testimony before a congressional

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committee. James Cooper and William Kovacic, an FTC attorney and commissioner respectively, told the committee:

No one seriously disputes the need for some form of professional regulation in the presence of large information asymmetries and serious spillover effects. In most cases it is difficult, if not impossible, for a consumer to judge the quality of her physician or attorney, and these practitioners are unlikely to internalize the full costs of their mistakes. Some level of state credentialing and regulation makes sense. In other areas, however, the need for stringent licensing requirements and regulation seems less obvious.

But Cooper and Kovacic are wrong. There *are* people who seriously dispute the need for some form of professional regulation of health care providers—Milton Friedman among them. In his 1962 classic, *Capitalism and Freedom*, Friedman wrote,

I am myself persuaded that licensure has reduced both the quantity and quality of medical practice; that it has reduced the opportunities available to people who would like to be physicians, forcing them to pursue occupations they regard as less attractive; that it has forced the public to pay more for less satisfactory medical service, and that it has retarded technological development both in medicine itself and in the organization of medical practice. I conclude that licensure should be eliminated as a requirement for the practice of medicine.

#### LICENSING FOR BRAIN SURGERY?

Supporters of medical professional licensing point to the presence of information asymmetries between patients and physicians. Economist George Akerlof explained this market failure in a famous 1970 *Quarterly Journal of Economics* paper, arguing that government regulation may be appropriate in situations

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where consumers are at an informational disadvantage relative to sellers of goods. But he also pointed out the potential for markets to resolve information asymmetries on their own. Although he failed to discuss the incentives that result from liability, he identified brand name and certification as important institutions that may resolve quality uncertainty. He pointed out that education and labor markets make use of brand names to guide employers and consumers.

Comments by two Supreme Court justices, Stephen Breyer and Antonin Scalia, reveal the extent to which Americans misunderstand the protections offered by state licensing. Discuss-

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ing the composition of licensing boards during oral argument related to *North Carolina State Board of Dental Examiners v. FTC*, Justice Breyer said, "I would like brain surgeons to decide [who can practice brain surgery in this state]." Justice Scalia agreed, "I want a neurologist to decide...." Yet in the United States, state licensing boards *do not* decide who actually conducts brain surgery. Medical licensing is not specialty-specific; licenses are given to graduates of medical school who have passed a comprehensive exam. They are not evaluated for specialty-related training, skills, or experience.

Instead of government-sanctioned licensing boards, hospitals decide who may practice neurosurgery. Members of a hospital's medical staff credential and privilege medical professionals, determining exactly what an individual may do. They verify and evaluate the education, skills, experience, malpractice history, and competency of each individual medical professional before the individual is granted the right to perform specific tasks. Health maintenance organizations go through much the same procedure, verifying a wide range of background information when they establish networks or panels of physicians from whom patients may seek care. They do this because they might be held liable for a mistake made by a credentialed care provider, and because their reputations matter.

Medical professional liability insurance (malpractice) companies also provide oversight. They review physicians annually, again looking at education, skills, experience, malpractice history, and

competence. They may deny coverage for certain procedures if a physician's record warrants, or deny coverage entirely.

The only specialty-specific certification that can be observed directly is that provided by private medical specialty boards. Most doctors have a medical specialty board certificate framed on their office wall.

## CARTELS AND PATIENT PROTECTION

Instead of vetting physicians, the licensing apparatus provides an avenue for professional influence that has been used to restrict entry, limit competition, and preclude innovation in the provision of health care. Only in states like Alaska, where physicians' care is difficult to access in rural areas, have professional interests to limit competition been set aside to experiment with new structures of care. The good news is that, freed from the restrictive scope of practice rules, innovation can lower costs and improve access with no apparent effect on quality. It is a win-win situation for all but physicians seeking to protect their traditional turf.

The similarities between the actions of state licensing boards and a cartel are striking. Government regulations facilitate the type of entry restrictions a private cartel

would have difficulty enforcing. By dictating the required level and type of training, state regulations benefit the licensed profession at the expense of consumers. The regulatory apparatus also allows politically powerful physician groups to limit the scope of practice of non-physician clinicians.

State licensing works poorly, if at all, to protect patients. It is routine for state-licensed physicians with alcohol or drug addictions to continue to practice while they participate in an approved treatment program. Few medical professionals are sanctioned by their state boards. In fact, most physicians who are categorized as high risk by medical professional liability insurance companies (based on valid malpractice claims) have never been sanctioned by a state board. One estimate is that only about a quarter of physicians in the high risk insurance market have ever been sanctioned by a state board in their entire careers. The good news for patients is that professionals who are denied malpractice insurance will be denied access to practice in hospitals and excluded from networks and panels.

State licensing does little more to protect consumers than confirm graduation from a program accredited by the Liaison Committee on Medical Education (LCME). Through the LCME, the American Medical Association influences medical school enrollment and the supply of physicians. Hospitals, health insurance companies, malpractice insurance companies, and others with some degree of liability evaluate job-specific training, skills, and malpractice risk before affiliating with medical professionals.

## EVOLVING PRIVATE OVERSIGHT

Widespread misconceptions about the sources of patient protection are probably a result of dramatic changes that have taken place behind the scenes. In the past, the majority of physicians practiced independently or in small groups. Today, the majority of physicians are employed by entities that share in the liability for negligence or substandard care. This provides an incentive for a level of oversight; in contrast, state boards are not liable if they fail to sanction a malfeasant physician.

Hospital and insurer liability have grown significantly over time, increasing incentives for oversight. Some individuals, concerned about the negative consequences of state licensing, suggested institutional licensing as an alternative. Providers such as hospitals would be responsible for physician oversight. Over the last decades, institutional oversight has evolved organically with increased institutional liability, making state oversight unnecessary.

Another important development is the growing importance of branding in health care. Brand name used to be nearly absent in health care markets, giving consumers little to go by but physician referrals and word of mouth. That is no longer the case.

An example of the use of branding is the Mayo Clinic Care Network, which has 30 associated medical centers. A billboard in Kingman, Ariz., advertises the connection between Mayo and the Kingman Regional Medical Center. Similarly, the Cleveland Clinic Affiliate Network includes 18 locations in the United States. Cancer Centers of America advertises heavily and includes five regional medical centers. Kaiser Permanente owns and operates 35 hospitals in California, Hawaii, and Oregon, and contracts with providers in Colorado and several other states. Providence owns hospitals in five states. Physician groups are increasingly under the brand umbrella, as hospital chains like Providence affiliate with physician groups like the Facey Medical Group in Los Angeles. As in other markets, brand name is an asset, resulting in strong incentives for those who hold the brand name to defend it by acting to protect those they serve.

Another beneficial development is the changing role that the medical malpractice insurance industry has played in managing risk. In the late 1970s, when economist Patricia Danzon and others studied the market, malpractice premiums were based on a physician's specialty and location, and there was little to no experience-rating of premiums. That left problem physicians without a strong incentive to manage risk. Today, medical malpractice insurance premiums are highly experience-rated. Physicians with valid claims or other risk factors face significantly higher rates, up to five times as high, creating a financial incentive to reduce practice risk.

The incentives associated with experience rating are complemented by the guidance of malpractice insurance companies that specialize in helping the most troubled physicians reduce practice risk. Medical professional liability insurance companies compile and analyze data on adverse events in specific practice

areas and aggressively encourage physicians to adopt risk management strategies.

Private certification has grown tremendously in the last decades. For example, almost all newly minted physicians are certified by medical specialty boards linked to one of three organizations that oversee the certification of physicians in 26 areas of practice. These boards are working on strategies to assess continuing competence beyond initial certification.

## CONCLUSION

The FTC has outlined specific recommendations for state legislators considering occupational licensing laws—recommendations that are germane to the statements the FTC, itself, has made defending state licensing of health professionals. The FTC has encouraged legislators to insist upon evidence that licensing restrictions “protect against demonstrable harms or risks.” Yet there is no evidence that state medical professional licensing laws protect patients from demonstrable harm or risk.

Widespread ignorance of the sources of patient protection has perpetuated a structure that facilitates physician efforts to limit competition and innovation. The premise that patients' health and safety are protected by state medical professional licensing is without basis. Instead, patients are protected by private credentialing, privileging, certification, brand name, medical professional liability insurance oversight, and other efforts to reduce liability. R

## READINGS

- “Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?” by Shirley Svorny. *Policy Analysis* No. 685, Cato Institute, October 2011.
- “If Professionals Are Just ‘Cartels By Another Name,’ What Should We Do About It?” by David A. Hyman and Shirley Svorny. *University of Pennsylvania Law Review Online*, Vol. 163 (2014).
- “Increasing Access to Health Care,” by Devon M. Herrick and Shirley Svorny. In *Enterprise Programs: Freeing Entrepreneurs to Provide Essential Services for the Poor*, edited by Roger Koppl; National Center for Policy Analysis, 2011.
- “Licensing Doctors: Do Economists Agree?” by Shirley Svorny. *Econ Journal Watch*, Vol. 1 (August 2004).
- “Medical Licensing: An Obstacle to Affordable, Quality Care,” by Shirley Svorny. *Policy Analysis* No. 621, Cato Institute, September 2008.
- “Prepared Statement of the Federal Trade Commission on Competition and the Potential Costs and Benefits of Professional Licensure before the Committee on Small Business, United States House of Representatives,” prepared by the Federal Trade Commission. July 16, 2014.
- “The Changing Role of Licensure in Promoting Incentives for Quality in Health Care,” by Shirley Svorny. In *American Health Care: Government, Market Processes, and the Public Interest*, edited by Roger D. Feldman; Independent Institute, 2000.
- “The Potential of Institutional Licensing and Brand-Name Advertising in the Medical Care System,” by Andrew K. Dolan. *Journal of Contemporary Business*, Vol. 9 (1980).
- “The Privilege Process: How Doctors Get Privileges at Hospitals,” by Jim Obert. *Southeast Missourian*, June 21, 2006.
- “U.S. Convergence with International Competition Norms: Antitrust Law and Public Restraints on Competition,” by James C. Cooper and William E. Kovacic. *Boston University Law Review*, Vol. 90 (2010).