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## The Economic Effects of Compulsory Medical Licensing

Vivek Rajasekhar

### *Too Many Patients, Too Few Doctors*

Kamela Christara, a 47-year-old single mother with Lyme disease in western Massachusetts can't find a personal physician. After calling three dozen practices, she has resorted to the emergency room at Cooley Dickinson hospital in Northampton when health problems arise. Christara is not alone in her difficulties. Since that state's landmark health care reform was signed into law in 2006 by then-Governor Mitt Romney, Massachusetts has suffered acute doctor shortages in ten specialties, ranging from primary care to neurologists.<sup>1</sup> A flood of previously uninsured residents now threatens the fragile network of health care providers. A study by the Massachusetts Medical Society found "critical" shortages in family practice and internal medicine, while a recent NPR story revealed that Holyoke Health Center in Holyoke, MA has over 1,600 newly-insured persons on its waiting list.<sup>2</sup> The average waiting time for a new appointment stretches to 53 days, the longest it has been in 6 years.

Although the situation in Massachusetts is particularly severe, the state is not alone in facing chronic doctor shortages. "The country needs to train 3,000 to 10,000 more physicians a year — up from the current 25,000 — to meet the growing medical needs of an aging, wealthy nation" says a recent article in USA Today. "Because it takes 10 years to train a doctor, the nation will have a shortage of 85,000 to 200,000 doctors in 2020 unless action is taken soon."<sup>3</sup> While journalistic inquiry into the cause of this shortage usually attributes the problem to the usual suspects- disparities in reimbursement rates set by insurance companies, Medicare, and Medicaid, administrative work burdening physicians- the root cause of persistent shortages of qualified medical professionals remains unexamined. The supply of physicians in the United States does not respond to market forces, but rather, to political considerations. To practice within a state, clinicians must obtain certification from that state's licensing board. One view of this is that it maintains quality within the health care system by ensuring that only qualified doctors may treat patients. In reality, licensure represents a barrier to entry that physicians interest groups have erected in order to restrict competition within the field. The economic effects are predictable- a decrease in supply of physicians and a drastic increase in their median wages. Meanwhile, the policy fails to protect consumers from incompetent doctors, and by raising the marginal cost of care, reduces the affordability of quality care and restricts patients' access to treatment.

### *The Shortage*

Nobel Prize-winning economist George Stigler outlines in his Theory of Economic Regulation,<sup>4</sup> "[the state], with its power to prohibit or compel... can and does help or hurt a vast number of industries.... regulation, as a rule, is acquired by the industry and is designed and operated primarily for its benefit." Mandatory medical licensing is a prime example of a regulation demanded by an industry (doctors) for their personal benefit (higher wages), and falls into the traditional framework of occupational licensing. At present, some states regulate over 500 professions in this manner, ranging from hairdressers to lawyers. While some rules simply require the individual's name on a list, others demand an extensive process of testing, evaluation, and oversight. Medicine tends toward the latter. As the European Institute of Business Administration Professor S. David Young points out, "indeed, it appears that every organized occupational group in America has tried at one time or another to acquire state licensure for its members. Today at least a fifth, and perhaps as much as a third of the work force is directly affected by licensing laws."<sup>5</sup> The argument in favor of licensing laws is that it protects the general public from shoddy workers- the "incompetents, charlatans, and quacks." In truth, licensing acts as a barrier to entry, the term used by economists to signify an obstacle that exists in entering a market. By placing on-

erous requirements on the education of aspiring professionals (at great expense to them), and due to the limitations on the licensing boards' willingness to hand out certification, this form of regulation can effectively create a shortage, where prior to, none would exist.

In the case of the manufacturing a doctor shortage, the American Medical Association is the primary promoter and enforcer of compulsory medical licensing. Despite only representing 19% of American doctors, the AMA is considered one of the most powerful trade unions in the world. At the time of the country's founding, America's medical system contained a variety of healers, such as herbalists and hydrotherapists, in addition to the modern allopaths and osteopaths. Beginning in 1847, the American Medical Association began organizing to represent the interests of allopaths. At its founding convention in Philadelphia that year, one of the primary objectives outlined was the "upgrading of medical education and concomitant reduction in the number of physicians."<sup>6</sup> Nevertheless, Census data indicates that in 1860, the United States possessed over 55,000 physicians, or roughly 175 per 100,000 citizens, one of the highest percentages in the world. Over the course of the next two decades, the AMA became more focused with regard to its ultimate goal. At a meeting in Cincinnati in 1867, the organization endorsed a resolution urging members to "use all their influence in securing such immediate and positive legislation as will require all persons, whether graduates or not, desiring to practice medicine, to be examined by a State Board of Medical Examiners, in order to become licensed for that purpose." Thus began, in earnest, efforts to use medical examining boards as a conduit for entry into the profession. The first attempt at setting up these institutions came in 1874, when the State of Kentucky instituted the Kentucky Board of Medical Licensure. The AMA's efforts culminated with the production of the Flexner report in 1910, which sanctioned allopathic medical schools and condemned homeopathic ones.<sup>7</sup> Flexner pushed for the licensing of doctors and hospitals and government subsidies for medical research, with Congress and state governments acting swiftly on these recommendations. By 1915, only Alabama, Colorado, and New Mexico did not require a diploma in medicine nor an examination of applicants as a prerequisite for practice.

The number of medical schools began to precipitously drop. In 1910, before the publication of the Flexner report, there were 130 medical schools in the United States. By 1944, there were just 69. The effect on doctors' income was just as swift and remarkable, albeit in the opposite direction. Dale Streinrich points out,<sup>8</sup>

*"While physician incomes and prestige dramatically increased, so did the caregiving workload. Wolinsky and Brune (1994) report that doctors were firmly in the lower middle class at the time of the AMA's founding and made about \$600 per year. This rose to about \$1,000 around 1900. After Flexner, incomes began to skyrocket such that a 1928 AMA study found average annual incomes reached a whopping (for the time) \$6,354. Even during the Great Depression, physicians earned four times what average workers did. A 2009 survey put family-practice doctors (on the low end of the physician income range) at a median of \$197,655 and spine surgeons (at the high end) at a median of \$641,728. These figures are mind boggling to ordinary Americans, even in good economic times. In addition, the cyclical unemployment that throws workers out of jobs in almost all other industries with the arrival of recessions or depressions became nonexistent among physicians after Flexner."*

The shortage in doctors and number of medical schools has persisted until today. Only one new medical school was established during the 1980s and 90s.<sup>9</sup> During this period, the population of the United States increased 29%, from 238 million to 308 million. As University of Michigan economics professor Mark Perry summarizes, "the supply of medical school graduates has remained basically flat for the last 30 years. At the same time, the demand for physicians' services has increased over time because of a population that is both increasing and aging (fig. 1)."<sup>10</sup>

### ***Consequences and Solutions***

The traditional justification given for strict medical licensing, as with other forms of occupational licensing, has been to keep poor-quality clinicians out of practice. In theory, only practitioners that meet some threshold of capabilities can obtain their license. Since this argument is uncomplicated and can be communicated to laymen with ease and clarity, there is little to no opposition by society. Moreover, because the monetary benefits of licensing are concentrated in such a small group that lobbies heavily in its favor, but the policy's costs are spread out amongst the relatively uninformed general public, occupational licensing is politically very difficult to oppose. However, contrary to conventional wisdom, there is little empirical evidence that medical licensing actually improves the quality of care, or even that it prevents bad practitioners from continuing treatment. State medical boards often rely on private organizations to perform many of the background checks and testing functions, organizations that could continue to provide credentialing services in a private capacity even in the event of the board's termination. Medical boards also have a poor record at disciplining errant providers. Often, colleagues do not report if they know a physician has committed a serious medical error, and if they do, they did not necessarily report them to the state medical board, but instead to their employer. Because establishing proof of substandard care is an expensive affair, requiring expert testimony, lawyers, and witnesses, licensing boards do not investigate a large number of claims. A study of Florida physicians with malpractice payouts found that only 16% were sanctioned by that state's medical board.<sup>11</sup> Another report looking at doctors with ten or more malpractice payments between 1990 and 2005 found that only one-third had even been disciplined by their supervising licensing board.<sup>12</sup> To make matters worse, there is a pattern of reluctance at reporting negative outcomes to the public. The Federation of State Medical Boards' records show that, in more than 65% of cases, the medical board and the offending physician reached an agreement without the physician being found guilty, thus denying consumers an important record of low-quality physicians to avoid.<sup>13</sup>

Further, medical licensing commissions have justified their existence by requiring clinicians to obtain higher and higher levels of education to perform the same functions, even if there is little evidence that more degrees actually improves patient care. For example, in 2012, California will begin requiring audiologists to obtain a doctorate (Au.D.), a requirement the *Sacramento Bee* has called an "extraordinary and costly mandate."<sup>14</sup> "The relationship between educational inputs and better health outcomes," California State University- Northridge economics professor Shirley Svorny says, "is not that straightforward. It is not clear that those excluded by these high barrier to entry would not be competent practitioners." Mandating increasingly high levels of education to perform the same functions restricts employers, such as hospitals and clinics, from choosing among a wide range of education and training options. By limiting entry into the medical profession, onerous educational requirements can result in worse outcomes. These policies have also helped drive domestic health care costs skyward over the past several decades. As the Kaiser Family Foundation notes, U.S. health care spending was \$7,681 per resident in 2008, amounting to 16.2% of the nation's GDP, the highest percent among industrialized countries. Health care expenditures were \$2.3 trillion in 2008, over eight times the amount spent three decades ago.<sup>15</sup> As one of the primary inputs into the production of health care, physicians' wages are a significant portion of that inflation. The price of the extra years of mandated schooling, both in terms of its direct cost (tuition) as well as the opportunity cost of the lost wages during those years, is factored into the final price charged to the ultimate consumer of health care, the patient.

Unfortunately, the persistent shortage of physicians also manifests itself in other ways. Waiting lists have become commonplace in medicine as a form of rationing the limited supply of health care services. In 1993, the average wait time from when a patient receives a referral to when they can see a specialist was 9.3 weeks. By 1997, that period was up to 11.7 weeks, and currently sits at 17.3 weeks.<sup>16</sup> With the recent passage of the Patient Protection and Affordable Care Act, bringing an expected 36 million new patients into the health care system, these wait times are only expected to be further lengthened. Other

consequences of doctor shortages and wait lists is the reduced time busy physicians can spend with any given patient, as well as the impinged health of patients that must go without a primary care physician.

One of the major counterarguments to an unrestricted market for medical professionals is that it opens the door to “quack” doctors. However, according to Svorny, “medical licensing is ineffective and inefficient, and patients would be better served by relying on brand recognition when choosing their doctors.”<sup>17</sup> Individuals searching for a physician or surgeon could use referral, word-of-mouth, or simply visit a reputable group practice or hospital. Patients could also evaluate health professionals on the basis of price and quality, much as they do when purchasing a car or eating at a restaurant. To this end, many economists have suggested making publicly available doctors’ qualifications- the degrees they hold, number of years experience, statistics on patient outcomes- and allowing patients to decide which practitioners to visit based on this information. Also, medical malpractice serves a useful function with regard to eliminating incompetent doctors. An effective tort system for medical malpractice will accrue heavy costs on irresponsible doctors, driving them from the marketplace. Further, malpractice insurers offer discounts to physician groups that successfully reduce medical errors, or alternatively, penalizing physicians that engage in “negligence-prone behavior” with higher premiums.<sup>18</sup> On the other hand, hospitals tend to self-insure, and thus have a strong incentive to monitor the performance of their clinicians over time.

It is difficult to predict precisely what regulatory features would develop in the absence of official government licensing. Yet, as one of the the most influential economists of the 20<sup>th</sup> century, Milton Friedman, explains, “the great argument for the market is its tolerance of diversity.... It renders special groups impotent to prevent experimentation and permits the customers and not the producers to decide what will serve the customers best.”<sup>19</sup> Perhaps the most simple and direct route is to allow private credentialing in medicine- competing degrees, such as M.D.’s, D.O.’s, and whatever alternatives new organizations design. Individuals can choose what combination of education and licensing they prefer, and likewise, patients can choose what brand of physician they are most comfortable with. The accounting industry is one example of how medical licensure should operate. While any person can call themselves an “accountant” and open practice, numerous standards of certification exist to prove professional competency. These include, among many others, the Certified Internal Auditor (CIA), the Accredited Business Accountant (ABA), and the most widely-recognized, the Certified Public Accountant (CPA).<sup>20</sup>

### ***Conclusion***

While proponents of medical licensing state that these policies were instituted as a mechanism to protect patients, the evidence suggests that they have not helped to remove incompetent doctors from practice, but rather, have created an acute shortage of doctors throughout the American health care system. Consequently, patient treatment has become more expensive and of lower quality. This form of occupation licensing is deliberate policy of organizations, including the American Medical Association, which use government regulation as a mechanism to raise the wages of the special interest group they represent, American doctors. A better system exists- one that balances safety with cost and access. This requires relying on the market forces to control the supply of doctors, utilizing the “invisible hand” that Adam Smith wrote about over two centuries ago. It means allowing consumers to choose physicians with competing standards of certification and forms of education, in order maximize innovation and efficiency. Based on the failure of the status quo, patients have little to lose, but much to gain from eliminating mandatory medical licensing.

Figures

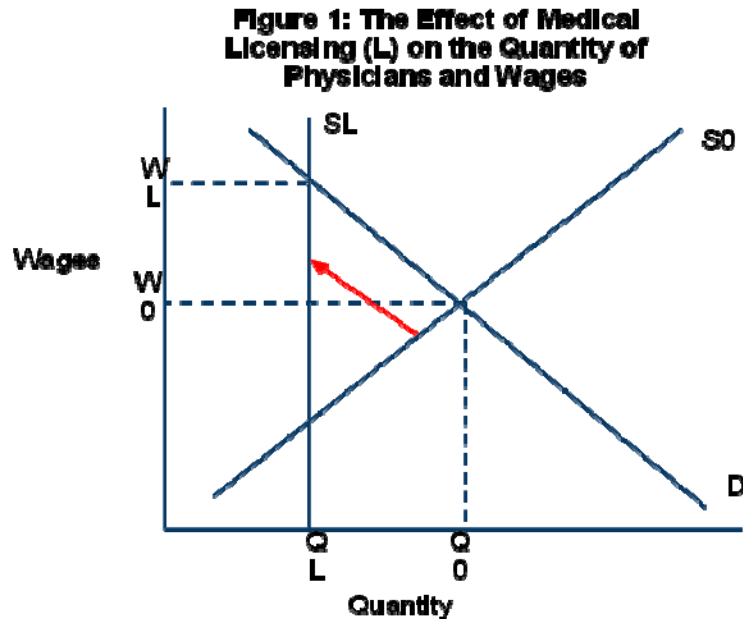


Figure 1 demonstrates the empirical effects of medical licensing on doctor quantity and wages. Because licensing boards are only apt to hand out a fixed number of licenses for practice (a number that is now also restricted because of the limited number of medical schools), the supply for physicians shifts to a perfectly inelastic position ( $S_L$ ). The result is that the quantity of doctors under licensure falls to  $Q_L$  and their equilibrium wage rises to  $W_L$ .

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