

Comments on FTC Economic Liberty Task Force Roundtable: The Effects of Occupational Licensure on Competition, Consumers, and the Workforce: Empirical Research, November 7, 2017 (page numbers below refer to the roundtable transcript available on the FTC web page)

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EMPIRICAL WORK

First you asked about empirical work in this area:

In this article (2000), I tried to include all sources that had empirical evidence on licensing that were available at that time: <http://www.csun.edu/~vcecn007/publications/EncyclopediaEntry5120book.pdf>.

Also by me:

<http://www.csun.edu/~vcecn007/publications/PhysicianLicensureEconomicInquiry1987.pdf>.

Here is the abstract: ...economists have debated the extent to which organized medicine has benefited from medical licensing restrictions. This debate has been hampered by the lack of a viable alternative hypothesis. This paper provides an alternative hypothesis and suggests an empirical test which focuses on the relationship between licensure restrictions and the level of consumption of physician services across states. *The evidence suggests that in the mid-1960s the interests of organized medicine dominated those of consumers in influencing the medical regulatory supply process.*

ECONOMIC THEORIES OF CONSUMER PROTECTION

Page 6: Kleiner mentions how markets protect consumers but he fails to mention brand name (concern about reputation). With growing concentration in health care markets, brand name is of increasing value. For example, the Mayo Clinic Care Network uses its brand name to reassure patients at the Kingman Regional Medical Center in Arizona, <http://www.azkrmc.com/mayo-clinic/>.

Page 7: Kleiner talks about “very clear benefits” in “shielding the public against ‘the untrustworthy, the incompetent, or the irresponsible.’” That cannot be used to justify medical professional licensing. There is absolutely no evidence that limits on scope of practice benefit consumers or that increases in the required level of education/training for all graduates (say in physical therapy or audiology) benefit consumers.

Page 17-18: Redbird’s argument does not justify licensure, certification would do as well. Van Binsbergen makes this point on page 20. On page 35, Timmons says certification “perhaps combined with some other means, may well accomplish the same thing.” (To what “other means” is he referring?) This is what most economists conclude, as I’m sure you know.¹ Van Binsbergen makes the point on page 38 of the FTC transcript.

¹ Svorny, Shirley. 2004. Licensing Doctors: Do Economists Agree. *Econ Journal Watch*, https://econjwatch.org/file_download/54/2004-08-svorny-reach_concl.pdf?mimetype=pdf.

Economists Carl Shapiro and Hayne E. Leland both developed theories to explain how medical licensure could benefit consumers.² But both concluded certification would yield an equivalent result. I outlined their theories here: *Advances in Economic Theories of Medical Licensure*, *Federation Bulletin: The Journal of Medical Licensure and Discipline*, 80(1):27-32, 1993, <http://www.csun.edu/~vcecn007/publications/c.pdf>. I wrote a paper that presents an economic justification for licensure relative to certification.³ I discuss it in “Advances in Economic Theories...” as well. I argued that licensing creates a premium stream (in the form of higher earnings) that creates a significant loss if physicians engage in malfeasance. Like other premium streams (or steep wage profiles in labor markets), it can be of value because the actions of physicians are hard to monitor. This same idea, but for taxi licenses, is in an article by Gallick and Sisk, https://www.jstor.org/stable/764807?seq=1#page_scan_tab_contents, Gallick was at the FTC at the time. They explain the reason tourist-style occupations may be licensed (see Redbird’s concerns on page 27 of the FTC transcript). There are externalities associated with treating tourists poorly and a premium stream — the result of barriers to entry -- can modify their behavior. Of course, Yelp and similar apps may resolve this problem without limiting entry.

CONSUMER PROTECTION

First, an important point. Licensure can’t protect consumers from the widespread use of medical practice patterns that kill or harm patients (hospital borne infection, overdiagnosis, and others). Most of what medical professionals do for patients has not been empirically tested.⁴ Second, there are limits to improving health given how people behave (unsafe behaviors).

Page 3: Acting Chairman Ohlhausen mentioned *consumer protection*:

...the FTC recognizes that licensing sometimes serves important consumer protection functions and addresses certain types of market failure, especially in situations where consumers may be vulnerable, because they lack sufficient information to evaluate the quality of service providers. A classic example is health care, where the state has a strong interest in preventing unqualified people from providing certain health care services that pose risks to patients’ safety and where consumers may find it difficult to evaluate whether a provider is qualified or not. [Underlining added.]

However, when it comes to consumer protection, the fundamental justification for licensing, consumers don’t have to be able to evaluate physicians. Providers (hospitals, HMOs, PPOs, etc.) evaluate physician

² Shapiro, Carol. 1986. Investment, Moral Hazard, and Occupational Licensing. *Review of Economic Studies*; Leland, Hayne E. 1979. Quacks, Lemons and Licensing: A Theory of Minimum Quality Standards. *Journal of Political Economy*; Leland, Hayne E. 1980. Minimum Quality standards and Licensing in Markets with Asymmetric Information. *Occupational Licensure and Regulation*, ed. By Simon Rottenberg, American Enterprise Institute for Public Policy Research.

³ Svorny, Shirley. 1987. Physician Licensure: A New Approach to Examining the Role of Professional Interests, *Economic Inquiry*, <http://www.csun.edu/~vcecn007/publications/PhysicianLicensureEconomicInquiry1987.pdf>.

⁴ See, for example, Kumar, Sanjaya and David B. Nash. 2011. Health Care Myth Busters: Is There a High Degree of Scientific Certainty in Modern Medicine? *Scientific American*, <https://www.scientificamerican.com/article/demand-better-health-care-book/>

quality. They have sufficient information and the proper incentives (liability, reputation). Things have changed: (1) Consumer access to information, (2) consolidation and greater use of brand name, (3) shift in legal liability (to hospitals, HMOs and others who hire or affiliate with physicians), (4) use of experience-rated medical malpractice insurance premiums, and (5) higher rates of employed physicians. All of this works to increase *consumer protection*.

- Providers and insurance companies are liable and have reputations to protect. See my paper on medical liability insurance and patient protection:
<https://object.cato.org/sites/cato.org/files/serials/files/regulation/2015/3/regulation-v38n1-6.pdf>
- Liability shifted away from the individual physician and to hospitals, HMOs and others some time ago, as I note in these two papers:
<http://www.csun.edu/~vcecn007/publications/SvornyAmericanHealthCareFeldmanChapter.pdf>
<http://www.csun.edu/~vcecn007/publications/ShouldWeReconsiderLicensingCPI1992.pdf>
- On page 24 of the FTC transcript, Kleiner makes the point that increased access to information “reduces the need for a lot of the government regulation.” He makes it again on page 33, asking “what does licensing provide beyond what is available?” For a discussion of the role of information technology in *consumer protection*, see my paper,
<http://www.csun.edu/~vcecn007/publications/SvornyHalfLifePolicyRationalesChapter.pdf>
- Credential verification services (CVS) make state licensing efforts redundant (and, therefore, a waste of resources). Physicians can send all of their materials (medical school graduation, USMLE test scores, and residency training) to privately-accredited credential verification services. In order to remain accredited (by the Joint Commission, for example), hospitals, HMOs, nursing facilities, etc., routinely “verify” the same set of information that state licensing boards verify PLUS additional information on medical malpractice claims, loss of hospital privileges, loss of medical malpractice insurance, and other related measures.
 - The Federation of State Medical Boards has a credential verification service.
 - There are private companies as well. One company’s web page is here:
<http://www.pcv.net/> and this is what it says (in terms of reputation for *consumer protection*):
Professional Credential Verification Service, Inc. (PCVS) is a National Committee for Quality Assurance (NCQA)-certified and Utilization Review Accreditation Commission (URAC)-accredited Credentials Verification Organization (CVO). PCVS is a non-profit corporation which provides primary source credentialing verification services for hospitals, physician practices, health plans, and other health care organizations. PCVS is one of only six CVOs in the nation that is dually assessed by both NCQA and URAC.
 - To get a feel for credentialing (the result of liability and greater levels of affiliation and employment), see the Blue Cross and Blue Shield of Illinois Credentialing Standards, https://www.bcbsil.com/pdf/standards/manual/credentialing_standards.pdf; here is the form physicians must complete:
<https://www.cagh.org/sites/default/files/solutions/proview/paper-application.pdf?token=enguSSk2>. Note that doctors are asked about everything, including malpractice claims. Unlike licensing, this oversight occurs on a regular basis over time.

- Liability also offers *consumer protection* via the medical professional liability insurance market. Premiums are experience rated and “troubled” physicians are assisted in efforts to manage practice risk. Health policy analysts were wrong about the lack of experience rating in medical malpractice insurance markets. In their defense some wrote before experience rating was the norm. For a detailed description of how this works see http://www.csun.edu/~vcecn007/publications/MedicalMalpracticeCaps_Oct_2011.pdf

So the whole consumer protection argument is weak. If anything, state boards hurt consumers; they keep information from patients and allow malfeasant physicians to continue to practice while they are being investigated or when they participate in treatment (drug, sex, etc.) programs.⁵

OTHER POINTS

Page 26: Koch expresses the concern that the prescription behavior of NPs and MDs is different. However, as time passes these practitioners will be encouraged to review their prescription behavior if it is risky (malpractice insurers will identify this and work to inform clinicians or hospitals, HMOs, and others). If it is just expensive, but not risky, expect the HMOs, etc. to figure this out on their own. If the expensive alternative is reimbursed by Medicare, don’t expect any changes. (See Charles Silver and David Hyman’s new book coming out soon, *Overcharged*.)

P. 28: Wozniak says that insurance companies require licensure for reimbursement. First, the project researchers heard this from state agencies, groups that have an incentive to defend licensure. Second, I don’t see why insurance companies would ask this – I’d like to know more -- but maybe it is just to be sure they didn’t miss anything. It’s a low cost thing to check, but I doubt it tells the insurance companies much. The insurance companies have access to the National Practitioner Data Bank, but some state boards are slow to report sanctions.

Having a license does not mean that there are no state board actions against a physician. And the state boards are not great at identifying high-risk physicians; state board actions are uncommon among the physicians who apply for coverage in the high-risk malpractice insurance market. (See my medical malpractice paper, http://www.csun.edu/~vcecn007/publications/MedicalMalpracticeCaps_Oct_2011.pdf.)

P. 30: Wozniak says “We just cannot have an optimal situation with that much heterogeneity in it.” I’d argue that national standards are not the answer. Specifically, there are differences across states in population, I would imagine, that might justify heterogeneity in occupational licensing. She goes on to say, “if someone is proposing a new regulation...it seems that a clear first step is that this particular profession has to have a tight association with consumer health, safety, or welfare.” I just want to point out that a tight association with consumer health should not be a defining criterion. As I’ve pointed out,

⁵ Eisler, Peter and Barbara Hansen, Thousands of Doctors Practicing Despite Errors, Misconduct. 2013. *USA Today*; Levine, Alan, Robert Oshel, and Sidney Wolfe. 2011. State Medical Boards Fail to Discipline Doctors with Hospital Actions Against Them, Public Citizen, <http://www.citizen.org/documents/1937.pdf>; Consumer Reports, What You Don’t Know About Your Doctor Could Kill You. 2016. <https://www.consumerreports.org/cro/health/doctors-and-hospitals/what-you-dont-know-about-your-doctor-could-hurt-you/index.htm>.

licensing medical professionals (something most people would associate with health and safety) does not protect consumers. Consumer protection is generated by actions of private market participants. And they would kick up if consumers were not misled by licensing.

Wozniak goes on to say that dealing with children -- she uses the example of licensing janitors at her kids' daycare facility -- might be a case where "we are willing to spend a lot of money to ensure that we're getting a small amount of benefit." This is a bad example. Daycare facilities have a strong incentive to take steps that preclude illness (lice comes to mind). Plus, parents are there every day. Daycare programs need to protect their reputations. To this end, some daycare facilities even offer video access to parents, so they can see what is going on. This is not a situation where consumers can't monitor or assess care or sanitation. She is right, it is important, but the incremental benefits of mandating licensing are probably negative, as there may be no improvement in sanitation but it would increase the cost of day care and reduce access.

Page 32: Redbird says licensing and certification don't do the same thing. She says it is "a complex relationship between the task, the person, and then, of course, the data we have and what level that data is measured." I don't really understand this but certainly she would agree that we could certify clinicians instead of licensing them at the state level. It would be exactly the same in terms of the information provided to consumers, only with certification, non-certified clinicians would not be precluded from practicing in the market.

P. 33: Van Binsbergen makes the point that exam scores are not revealed. But it is well known that individuals with the highest scores get the best residencies. Also, brand name indicates quality. For example, a Chinese-educated doctor establishes a reputation in the U.S. by completing a fellowship in medical oncology at Yale. All doctors are not seen as equal in the market, some rise to be leaders in their fields. They are all licensed, but they are not treated as equal in the market. Milton Friedman made this point in *Capitalism and Freedom*, he said something like we don't just pick a physician from a list of licensed physicians.

P. 34: Redbird makes a great point, saying that testing and quality are not likely to be related. I psychologists have done research in this area.

P. 36: Redbird suggests that a clinician can say "I'm licensed in this state to do physical therapy, even though I did my education outside." My comment is that private companies would arise to certify foreign-trained clinicians. These companies would seek accreditation, develop a brand name, and consumers would trust them.