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The Coronavirus Pandemic Shows the Folly of Medical-Licensing Laws

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Of the many lessons of the COVID-19 pandemic, one of the most obvious is the need to reevaluate state-licensing laws that impede the free and rapid movement of health-care workers to places they are needed. Many governors suspended state-licensing requirements in early March so that doctors, nurses, and other health-care professionals licensed in other states could help with the public-health crisis in their own states. These governors should not resume the ways of the past when the crisis ends.

Individual state-licensing requirements for health-care professionals do not help patients or ensure quality. Rather, they serve as a mechanism to protect health-care provider interests.

From its inception in 1847, the American Medical Association sought to reduce the number of practicing physicians by promoting state-licensing laws. It was largely unsuccessful in its campaign until after the Civil War. Then state chapters of the AMA persuaded legislatures to enact licensure boards, claiming they would protect the public from gross incompetence. Unfortunately, as many victims of medical malpractice will attest, the granting of a license offers no such protection. Licensing restrictions do, however, restrict the supply of health-care providers at a time when America's aging population portends a physician shortage of crisis proportions.

When states that were badly hit by the COVID-19 pandemic removed licensing barriers, allowing doctors from outside states to practice medicine and to help their residents, the obvious question became why state medical restrictions were necessary in the first place. Is there a legitimate difference between the quality and necessity of additional certifications for a physician in Alabama versus Arizona?

The medical-school requirement, national medical-licensing examination requirements, and residency-training requirements are nearly identical in all state-licensing processes. Yet in most cases, a medical license is not transferrable from state to state.

A physician in New York City cannot practice medicine in New Jersey or Connecticut without three separate medical licenses using the same national-board examination, medical degree, and specialty training. These same licensing regulations prevent patients from receiving telemedicine from out-of-state providers. It's akin to a state prohibiting someone from driving on their highway with an out-of-state driver's license.

Furthermore, having a license does not ensure quality care. Private credentialing and certification organizations, such as the American Board of Surgery and the American Board of Neurological Surgery, do the vetting of practitioners' training and competency that health-care consumers need when seeking medical advice. Health-care consumer-rating sites such as *Healthgrades* or *Vitals* rate health-care providers, while sites lsuch as *Leapfrog* or *Consumer Reports* rate health-care facilities. Licensing boards provide no such tangible function.

Once they get a license, physicians in most states may practice any specialty they choose in their offices. Many hospitals or insurance companies, on the other hand, may require their panels of providers to be specialty-board certified. For example, a physician with no formal training or certification in psychiatry can post "psychiatrist" on the office door but would not be able to practice psychiatry in a hospital. Licensing doesn't protect people. Credentialing protects people by carefully examining and verifying physicians' depth of training and experience in the area in which they claim to have expertise.

State license boards' websites may be cumbersome to navigate. Consumers might find it a challenge to view and fully understand any out-of-state complaints a physician might have had prior to relocating in their state. Nobel Prize–winning economist Milton Friedman understood this when he criticized medical-licensing laws. The governance of physicians is best done closest to the physician at the hospital, group, or specialty certification level.

The licensure apparatus is also a money-making scheme. It costs $315 to get a license in Alabama. It costs $500 to get a license in Arizona. It costs $375 more to create the portfolio needed to help send the application through the Federation of State Medical Boards. On top of that are the general licensing-examination costs, which tally well over $1000. A cottage industry has developed to help physicians navigate the process. Over the past 100 or so years, "organized medicine" guilds have teamed up with legislatures to erect a hidden medical-licensing/industrial complex.

In 2019, Arizona became the first state to grant reciprocal recognition to all occupations holding out-of-state licenses in good standing that wish to set up operations within its borders. Shortly thereafter, Montana and Pennsylvania followed suit. Missouri became the latest state to do so this May. These are all steps in the right direction, but these states still require out-of-state licensees to maintain brick-and-mortar locations within their borders.

A better reform would be to define the "locus of service" as the state in which the provider holds the license, not the state in which the consumer resides. The United States is a 50-state free-trade zone. Consumers can purchase goods and services across state lines without obstructions. Yet they are barred from services provided by people who must obtain a state license to practice their livelihood.

Artificial shortages develop wherever there are barriers to entry by new providers. Medical-licensing laws artificially reduce the availability of physicians and the availability of care. By their emergency suspension of state-licensing laws, governors of states that are COVID-19 "hot spots" tacitly admitted as much. Hopefully the lesson in this will not be lost on those governors and their legislatures once the crisis is over. The suspensions should be made permanent and form a basis for a comprehensive overhaul of medical-licensing laws.

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