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Health Care Workforce Reform COVID-19 Spotlights Need for Changes to Clinician Licensing

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EXECUTIVE SUMMARY

The COVID-19 pandemic has made clear that government licensing of health professionals blocks access to care. Licensing gives state politicians the final word on allowable categories of clinicians, the education and training requirements for each category, and the range of services each category of clinician may perform. It reduces access to health services by increasing prices and reducing the supply of clinicians who can provide those services. It harms health professionals by preventing them from providing services they are competent to provide and by preventing capable individuals from entering or rising within health professions. By suspending such rules to improve access to care for COVID-19 patients, states have acknowledged that licensing prevents clinicians from providing services they are competent to provide.

A better solution than direct government licensing is a system in which states recognize third-party organizations that certify the competence of health professionals. In such a system, accredited educational institutions or certificate-issuing organizations would define clinician categories, determine scopes of practice for each

category, and certify the training or skills of individual clinicians. Third-party certification would allow innovative educational and certification programs, nontraditional career paths, incremental expansion of clinician skills and scopes of practice, and the creation of new categories of health care professionals. The result would be better career opportunities for clinicians and greater access to care for patients.

This system would eliminate the straitjacket that direct government licensing imposes on education, entry, and practice. It would remove politicians from complex and contentious questions on which they have no expertise. It also would generate innovative education and training programs that could increase access while maintaining or improving quality. Reformers offer many ideas for improving medical education that would allow health professionals to add to their knowledge and skills over time. Relying on third-party organizations rather than direct government licensing to certify health professionals would allow these reforms to proceed. Third-party certification would better prepare the health sector for crises such as the COVID-19 pandemic and enable the health workforce to respond to them faster.

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INTRODUCTION

Making quality health care as affordable and accessible as possible requires both ensuring that clinicians have adequate training for the services they provide and avoiding education and training requirements that unnecessarily increase prices. A cost-effective health care delivery system does not require clinicians to invest in training beyond what is necessary to do their jobs. “Optimal providers are those operating at the right level; these providers are not overqualified but have the appropriate level of knowledge and skills to complete the task.”¹

“Right-skilling” is the process of striking the proper balance between too much training and too little. A system that right-skills its clinician workforce continuously increases access to care by eliminating unnecessary education and training costs and allowing lower-cost paths to demonstrating competence to provide certain services.

Right-skilling the provision of health services can reduce prices and expand access. Hospitals in India make medical care more affordable by providing workers only such training as is necessary to perform specific jobs:

Women from rural villages with only rudimentary education, for example, are trained to use sophisticated equipment and manage the delivery of medical services, such as administering dialysis. Meanwhile, physicians practice at the top of their license, playing key strategic and supervisory roles, passing down knowledge and tasks to lesser-trained individuals wherever possible. Such de-skilling is a hallmark of organizational innovation. . . . The accumulation of knowledge and experience allows organizations to codify knowledge so less experienced individuals can perform tasks that previously required personnel with advanced training.²

Right-skilling occurs on a limited basis in the United States. Physicians, for example, are increasingly turning to midlevel clinicians

to perform certain tasks. One study found that from 2008 to 2016, the share of specialty practices that employ either nurse practitioners (NPs) or physician assistants grew from 23 percent to 28 percent while the share of primary care practices that do so increased from 28 percent to 35 percent. The study’s authors speculate that “downward price pressure from public and private payers [may be] making the lower costs of advanced practice clinician employment more attractive” to physician groups.³ In 2019, the Edward-Elmhurst Health system in suburban Chicago de-skilled the provision of immediate care by replacing 15 staff physicians with NPs. The health system explained, “Patients have made it very clear that they want less costly care and convenient access for lower-acuity issues (sore throats, rashes, earaches), which are the vast majority of cases we treat in our Immediate Care [facilities].” One of the physicians who lost their jobs acknowledged, “There definitely is a good share of lower-acuity things, which I think would be fine for a nurse practitioner to see.”⁴

Just as nurses right-skill tasks that physicians are overqualified to perform, other health professionals right-skill tasks that nurses are overqualified to perform. “The de-skilling of the nursing profession has been taking place for quite some time,” writes one nurse. “For example, we have phlebotomists and phlebotomy technicians to draw blood in certain healthcare settings.” Other examples abound.⁵

Right-skilling is critical to reduce costs across the spectrum of care. Academics and health care providers have proposed using right-skilling to reduce the cost of primary care by creating such new clinician categories as primary care technicians and community paramedics.⁶ “Psychiatric pharmacists . . . could help offset the shortage of psychiatrists by providing medication-management services.”⁷ Retired Mayo Clinic urologist Murray Feldstein argues that clinicians could learn to perform high-quality vasectomies in significantly less time than the 13 years it takes to earn a doctorate of medicine (MD) and qualify for specialty certification in urology.⁸ Oregon

recently began letting NPs perform vasectomies.⁹ Right-skilling could reduce prices for the procedure, create better-paying jobs for competent midlevel clinicians, and increase job satisfaction among higher-skilled urologists, who could then focus on patients with more complicated needs. Robert H. Brook, a physician and researcher at the RAND Corporation, argues that colonoscopies (a common screening for cancer) do not require a fully trained gastroenterologist, nor does routine cataract surgery require a fully credentialed ophthalmologist. Instead, Brook suggests that two years of focused education and training would yield professionals qualified to perform these procedures, vastly expanding patients' access to these services.¹⁰ Right-skilling could reduce the cost of bone marrow biopsies, tooth extractions, and countless other services.

Government regulation prevents right-skilling. The central feature of the U.S. system for educating and certifying health professionals is direct government licensing. Under this system, clinicians must receive a license from each state in which they practice. Each state government therefore determines what categories of clinicians may exist in that state and the range of services each category of clinician may provide (i.e., the clinician's "scope of practice").

Right-skilling does occasionally occur despite government licensing. In 2019, Indiana expanded the scopes of practice of emergency medical responders (to include administering flexible nasopharyngeal tubes into patients with obstructed upper airways, using pulse oximetry to measure blood-oxygen levels, and administering oral glucose to patients with low blood sugar), emergency medical technicians (to include administering continuous positive airway pressure ventilatory assistance, nebulized bronchodilators, beta agonists, and anticholinergics to patients who are struggling to breathe; monitoring and interpreting end-tidal carbon dioxide for patients with excess carbon dioxide in their lungs; and administering over-the-counter pain medication), and advanced emergency medical technicians (to include all of the above plus additional medications, including additional

pain medications).¹¹ In 2020, unrelated to the COVID-19 pandemic, Florida removed barriers to pharmacists administering flu vaccines.¹² As these examples suggest, right-skilling takes place largely at the margins of health care.

As a rule, direct government licensing operates as if its purpose is to prevent right-skilling. Licensing creates opportunities for incumbent clinicians to influence the rules for entering their profession and the scopes of practice of competing professions. Since competition from lower-cost clinicians and ways of delivering care threatens the incomes of incumbents, incumbent clinicians lobby state governments in favor of licensing and scope-of-practice rules that preserve their incomes by blocking such competition. Direct government licensing does little if anything to improve the quality of care, but it consistently increases prices and reduces access by imposing excessive training requirements, preventing clinicians from providing services they are competent to provide, blocking new categories of clinicians, and blocking alternative paths to certification.

As an alternative to direct government licensing, states could instead recognize third-party accrediting organizations that would certify the competence of individual clinicians, much like private specialty boards do. Third-party accrediting organizations could create new categories of clinicians and impose only such education and training requirements as have value to consumers, clinicians, and their employers. They could create alternative, competence-based paths to certification, rather than require clinicians to fulfill unnecessary or unnecessarily formal education requirements. A system of third-party certification could reduce existing regulatory constraints, improve access to care for patients, and improve labor-market opportunities for health professionals. In particular, it could make the medical workforce and medical education more flexible and better able to respond to public health emergencies such as the COVID-19 pandemic. Such certification organizations already exist and could take the place of direct government licensing.

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RIGHT-SKILLING VS. WRONG-SKILLING

Education and training are essential for providing quality health services. Maximizing access to quality health care requires right-skilling (i.e., striking a balance between too little and too much education and training). Requiring clinicians to receive more education and training than is necessary to do their jobs is *wrong*-skilling, which harms clinicians by unnecessarily restricting employment opportunities and harms patients by reducing access to care.

Consider nursing. Aspiring nurses can become state-licensed registered nurses (RNs) after obtaining either a two-year associate's degree in nursing or a four-year bachelor of science in nursing (BSN).¹³ In 2017, the New York legislature passed a law requiring all nurses to obtain a BSN within 10 years of initial licensure.¹⁴

To determine whether it is in the interest of patients to require all nurses to obtain a four-year BSN, the relevant question is not whether requiring all RNs to obtain a BSN produces benefits. Even if an additional increment of education or training could deliver some benefits to patients, that is not enough to justify requiring clinicians to undertake the additional time and expense required to receive that training. If it were, nurses would not exist—states would require all clinicians to obtain an MD plus board certification in their chosen specialty. The relevant question is whether any added benefits exceed the added costs that those requirements impose in terms of reduced employment opportunities, higher health care prices, and reduced access.¹⁵

Mandating that every RN receive the additional education and training associated with obtaining a BSN is an example of wrong-skilling, since not all RN jobs require the additional training that a BSN provides.¹⁶ It is conceptually akin to requiring all health professionals to be board-certified MDs. A BSN requirement harms workers by increasing the cost of nursing education and restricting entry into the nursing profession. It harms patients by reducing the

supply of nurses, increasing prices for nursing services, and reducing access to care.

Right-skilling requires policymakers to develop rules that free medical educators and health care providers to experiment with flexible education and training requirements to strike the proper balance between too little and too much training.

DIRECT GOVERNMENT LICENSING

Government licensing consistently fails the right-skilling test. It allows incumbent clinicians to control the education and training requirements for entry into their professions and the ability of other health professionals to compete with them. Incumbent clinicians use these powers to block entrants into their professions, to block other categories of clinicians from entering the markets for certain services they are competent to provide, and to block innovative education and training programs that could reduce entry barriers into their professions and competing professions.

Direct government licensing of clinicians thereby requires patients to pay higher prices than are necessary to receive care from clinicians who have more training than is necessary. From the perspective of clinicians, the resulting unnecessary requirements prevent competent individuals from entering the health professions; legislatively determined scopes of practice prevent clinicians from providing services they are competent to provide; and rigid systems of education and training saddle clinicians with unnecessarily high levels of educational debt.

Incumbent Control

Direct government licensing gives state politicians the final word on allowable categories of clinicians, the education and training requirements for each category, and the range of services each category of clinician may perform.¹⁷ When the political system controls medical education and market entry in this manner, it creates opportunities for

members of the regulated professions to enact barriers to lower-cost competitors.

At first glance, such incentives may seem beneficial. The self-interest of incumbent clinicians, who form a powerful political constituency, will motivate them to lobby to increase the levels of education and training that workers must receive to enter the health professions, and those higher standards will protect patients. The problem is, it is also in the self-interest of incumbent clinicians to bar market entry by lower-cost competitors whose clinical skills are of equal or higher quality, because those clinicians could take market share from incumbents. Indeed, incumbents have relatively little incentive to seek government protection from inadequately trained competitors because market competition and the medical malpractice liability system (see the “What about Quality?” section) will themselves punish low-quality providers.

The presumed experts on matters of medical education and training—incumbent clinicians and especially physicians—therefore have a stark conflict of interest. Incumbents’ incentives are primarily to demand *excessive* restrictions on the creation of new clinician categories, educational requirements for entrants into their professions and competing professions, and restrictions on the scopes of practice of competing professions. Incumbents face incentives even to demand restrictions that reduce patients’ access to care, because such restrictions keep incumbent incomes artificially high.

Direct government licensing gives incumbents the ability to impose such restrictions. Since most politicians have no relevant expertise when it comes to health workforce issues, they typically cede control of these decisions to the regulated professions (i.e., to the very incumbent clinicians who face those stark conflicts of interest). States uniformly recognize organizations run by incumbent clinicians as the sole accreditors of education and training programs for their professions. State medical boards require all physicians to graduate from programs accredited by either the Liaison

Committee on Medical Education—an organ of the American Medical Association (the AMA, which represents incumbent MDs) and the Association of American Medical Colleges—or the Commission on Osteopathic College Accreditation—an organ of the American Osteopathic Association, which represents incumbent doctors of osteopathy. The American Dental Association, the American Occupational Therapy Association, the American Optometric Association, the American Physical Therapy Association, the American Podiatric Medical Association, the American Psychological Association, and the American Speech-Language-Hearing Association all control accreditation of the training programs that in turn control entry into their professions.¹⁸

Since state licensing boards recognize profession-controlled national accrediting organizations as sole accreditors, those groups control both curriculum and the number of accredited programs that are the sole path into their respective professions. That power allows those groups to limit competition from entrants both directly, by limiting the supply of entrants (e.g., by limiting the number of schools or their capacity), and indirectly, by imposing unnecessary educational requirements that make entry cost-prohibitive for many would-be competitors. Control over curriculum further allows incumbents to stifle innovations in education and training that might otherwise increase competition and access to quality services.

Economists have long warned against allowing incumbents to control accreditation of education and training programs for their professions.¹⁹ In 1977, the Federal Trade Commission (FTC) warned of the “inherent conflict of interest” in allowing the Liaison Committee to accredit medical schools. The FTC suggested shifting accreditation to groups independent of the AMA and with wider representation.²⁰

Blocking Competition from Entrants

Examples of incumbent clinicians using licensing to enact high barriers to entry into their

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professions include New York’s BSN-in-10 law. The American Nursing Association (ANA), which represents incumbent nurses, has advocated since 1965 a legal requirement that all RNs obtain a BSN.²¹ New York enacted the law at the behest of the ANA-affiliated New York State Nurses Association.²² Other examples include dentists lobbying state legislatures to block the creation of “dental therapists,” who compete with dentists in more than 50 countries to offer lower-cost oral examinations and routine fillings and extractions.²³ They include recent requirements that entrants into the markets for audiology and physical therapy services must all earn clinical doctorates—despite the fact that many tasks these clinicians perform do not require such intensive and expensive training. The Accreditation Council for Pharmacy Education, the sole organization that accredits pharmacy schools in the United States, also requires a clinical doctorate as its entry-level degree.²⁴ Groups representing incumbent advanced practice nurses have set a long-term goal of requiring a clinical doctorate for entry into those professions.²⁵

A clinical doctorate is not something every pharmacist or advanced practice nurse needs. Whether a clinical doctorate is appropriate depends on the services a clinician will provide. Dampening competition by requiring a clinical doctorate raises barriers to entry into the profession and keeps wages artificially high for incumbent clinicians, who typically receive exemptions from the new requirements.

Physical therapy illustrates how imposing additional educational requirements limits upward mobility for individual clinicians. Physical therapist assistants must earn a two-year associate’s degree.²⁶ In the past, when licensed physical therapists needed to complete only a four-year baccalaureate program, physical therapist assistants who wished to become physical therapists could enter “bridge” programs that would apply some of their two-year associate’s degree credits toward a four-year baccalaureate degree. Today, all 50 states, the District of Columbia, and two U.S. territories require licensed physical therapists to

obtain a doctorate in physical therapy.²⁷ Not only does this requirement mean physical therapist assistants must pay for three to four more years of school, but it also prevents them from applying any of their associate’s degree coursework toward that graduate-level degree.²⁸

Requiring that all entrants into a profession obtain the highest, most expensive, and most time-consuming degree available (e.g., a doctorate) leaves health care providers no room for right-skilling based on potential job roles. Consider audiology. Several groups representing incumbent audiologists set up the Accreditation Commission for Audiology Education in 2002 to advocate for the doctoral requirement and to accredit doctor of audiology degree programs.²⁹ By the end of 2006, all master’s degree programs in audiology in the United States had closed.³⁰

The requirements for a doctorate illustrate that direct government licensing produces entry barriers that have nothing to do with improving the quality of care. The Liaison Committee requires medical school applicants to take undergraduate courses in the liberal arts, such as history, literature, and the social sciences.³¹ By itself, this requirement raises the question of whether the Liaison Committee’s curriculum requirements exist to ensure high-quality medicine or to protect the incomes of incumbent clinicians by raising barriers to entry into the profession.

Blocking Competition from Other Health Professions

In addition to using licensing to block competition from would-be entrants into their professions, incumbent clinicians use it to block competition from other types of clinicians. The Department of Justice reports, “Professional associations and individual providers have used a variety of strategies to limit entry by potential competitors and prevent unbundling and de-skilling of the services that they provide.”³²

Lobbyists representing each health profession seek to expand their own members’ scopes of practice, which expands the potential

market for those clinicians' services. But they also lobby to reduce the range of services that other categories of clinicians can perform, because such limits reduce competition for their professions—albeit at the cost of increasing prices and reducing access. The current system effectively vests “one type of professional with gatekeeping power over another.”³³

Direct government licensing therefore requires state lawmakers to arbitrate countless and contentious scope-of-practice decisions that they lack the expertise to adjudicate. Such decisions include whether states should allow the following: NPs to practice without physician supervision; NPs to perform bone marrow aspirations, chest tube placements, lumbar punctures, colonoscopies, colposcopies, breast biopsies, and vasectomies; pharmacists to administer vaccines or prescribe birth control; or oral and maxillofacial surgeons to perform elective facelifts, rhinoplasties, and eyelifts.³⁴

Opposing groups of medical professionals spend considerable resources on lobbying to influence the outcome of these decisions. The Texas Podiatric Medical Association spent over \$1 million between 2001 and 2010 lobbying the state to let Texas podiatrists treat patients' ankles. Texas medical and orthopedic associations waged a “massive and well-funded” lobbying campaign to block the proposal.³⁵ Nurses likewise resist right-skilling services they provide.³⁶ Nurses unions complain that “the hospital industry is trying to expand the scope of nurse's aides and medical assistants.”³⁷

Government licensing resolves such decisions in favor of the group with the most political clout. A salient example is the perennial and ongoing battles between physicians and NPs over the latter's scope of practice. Twenty-two states, the District of Columbia, and two U.S. territories allow NPs to practice independently. In these states, NPs may evaluate, diagnose, and treat patients—including prescribing controlled substances—on their own authority. Research indicates that allowing NPs to practice independently increases access to care (especially for children), reduces emergency-room visits, and makes care more convenient and

understandable.³⁸ Studies examining intensive and acute care settings find an association between use of NPs and physician assistants and improved outcomes.³⁹

The remaining states and territories limit their NPs' scopes of practice by prohibiting them from providing one or more of those services unless they do so in collaboration with a physician.⁴⁰ Physicians typically charge \$5,000 to \$15,000 annually for such supervision arrangements.⁴¹ The AMA boasts that in 2019, its lobbying efforts blocked more than 50 attempts to expand scopes of practice for midlevel clinicians in various states, including efforts in nine states to let NPs practice independently. “Patients deserve care led by physicians—the most highly educated, trained and skilled health care professionals,” the AMA writes. “Through research, advocacy and education, the AMA vigorously defends the practice of medicine against scope of practice expansions that threaten patient safety.”⁴² According to the Brookings Institution, however, “the academic literature finds no evidence of harm to patients associated with less-restrictive [scope of practice] laws” and therefore no evidence of benefit associated with the more-restrictive laws.⁴³ Yet 28 states and 3 U.S. territories continue to restrict NPs' scopes of practice, to require NPs to make such payments to physicians, and to reduce access to medical care, for no apparent benefit.

Politics has always dominated government efforts to license clinicians. In 1994, Yale Law School lecturer and associate dean Barbara Safriet wrote:

Whatever may be true of licensure's fundamental efficacy, one thing is clear: many licensure and statutory scope of practice laws governing non-physician providers include unwarranted provisions that erect unnecessary barriers to the full utilization of these demonstrably competent professionals. The eradication of these barriers is essential to fundamental health care reform.⁴⁴

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In 2011, the authors of *The Future of Nursing* wrote, “What nurse practitioners are able to do once they graduate varies widely for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work.”⁴⁵ In February 2020, a group of health workforce researchers wrote, “Policymakers are increasingly recognizing that differences in state laws and in the ways in which organizations deploy their workforces aren’t based on evidence regarding quality of care or safety. Rather, state laws and organizational policies are informed by lobbying by professional associations that jockey to impose their self-interested views.”⁴⁶

Blocking Competition from New Education and Training Programs

Direct government licensing allows incumbents to block innovative and lower-cost education and training programs, which has contributed to the stagnation of medical education. In effect, the Liaison Committee’s accreditation requirements mean that becoming a physician typically takes a decade or more. Aspiring physicians must generally spend eight years in school—four as an undergraduate and four in medical school—and then at least three additional years in a residency program. The high and rising cost of medical education has spurred some schools to find ways to shorten the time to graduation. Some programs integrate bachelor’s degree studies with medical school, allowing candidates to complete medical school in less than the standard eight years.⁴⁷ In 2014, California enacted a law to allow students at accredited medical schools to complete their medical education in three years, offering an alternative track for students “who demonstrate a high level of scientific and medical understanding” in the hope of “churn[ing] quality doctors out faster and with less student debt.”⁴⁸ A third of medical schools are reportedly considering creating three-year MD programs.⁴⁹

Notwithstanding these efforts, medical education remains extremely rigid. Leslie Fall, a medical-education entrepreneur and

adjunct professor at Dartmouth University’s Geisel School of Medicine, wrote in 2017, “Despite a flurry of curricular reforms in the past 10 years medical school has changed little over the last century.”⁵⁰ The problem, according to former Harvard Medical School dean Jeffrey Flier, is that “the current high-stakes accreditation process does not invite the kind of large-scale experimentation that could lead to improvement.”⁵¹

The rigidity goes beyond the formal requirements for entry into the profession. As early as the 1970s, Duke University law professor Clark Havighurst noted that the Liaison Committee’s control of medical education imposes a strict ideology within the medical profession:

The educational system subtly shapes such important aspects of medical practice as the balance between scientific and clinical skills, the relative emphasis on primary and acute care, and physicians’ tolerance for and skill in economizing. By limiting educational diversity, professional interests in medicine, as in other professional fields, successfully prevented the emergence of different traditions and of different types of professionals who might have served the consumer better.⁵²

Andrew Gavil and Tara Isa Koslov explain, “Regulation can create, promote, and reinforce a sense of normalcy around a particular hierarchy of professionals” and “perpetuate an approach that has become dated.” Legacy regulations “tend to entrench a specific business model and can forestall the development of new business models, even when not designed to do so intentionally,” thereby “embed[ding] that model as the only approach that can satisfy the regulations’ requirements.”⁵³

The accreditation requirements that grow from direct government licensing preclude alternative paths to clinical practice. They block, for example, the development of new programs that could allow individual clinicians’ scopes of practice to evolve over time and beyond

traditional professional-degree boundaries. As a result, licensing inhibits innovations in medical education that could reduce the cost of quality health services.

COVID-19 EXPOSES LICENSING AS A BARRIER TO ACCESS

The COVID-19 pandemic has forced federal and state policymakers, Republicans and Democrats, to acknowledge that clinician-licensing laws block access to care.

In a March 24, 2020, letter to governors, Secretary of Health and Human Services Alex Azar urged states “to extend the capacity of the health care workforce to address the pandemic.” The recommendations included removing barriers to right-skilling: “relax scope of practice requirements for health care professionals, including allowing professionals to practice in all settings of care . . . [and] any requirements for written supervision or collaboration agreements”; “allow physicians to supervise a greater number of health care professionals”; and “modify laws or regulations to allow medical students to conduct triage, diagnose, and treat patients under the supervision of licensed medical staff.”⁵⁴

In anticipation of a surge of COVID-19 patients, state officials took numerous steps to remove barriers to right-skilling. Several states allowed medical and nursing students and recent graduates to perform services they are competent to provide and/or made education requirements in those programs less restrictive. Some states expedited the graduation of medical and/or nursing students (e.g., Alaska, Louisiana, Rhode Island). Some granted temporary licenses to medical residents and/or nursing students (e.g., Arkansas, California, Pennsylvania, Rhode Island). Some allowed certain medical and nursing students to provide services without a license (e.g., Delaware, Kentucky, Minnesota, New York).⁵⁵ (The British National Health Service likewise deployed medical students to cope with the crisis.⁵⁶) Some U.S. states expedited the licensing process for recent graduates of pharmacy, physician assistant, and

respiratory care programs (e.g., Indiana, Iowa) or nurse aide trainees (Oklahoma). Kentucky provided provisional licenses for certain licensing exam applicants. Iowa, Michigan, and other states allowed nursing schools to replace actual clinical experience with simulated clinical interactions.⁵⁷ Wisconsin allowed nurse aide training programs to reduce the number of required training hours and allowed new RNs to conduct such training.⁵⁸ At least one state, Wyoming, allowed nursing schools to make sweeping changes to their curricula. “At present there is no need to present substantive changes to the Wyoming State Board of Nursing,” the board wrote to nursing school program directors. “We trust your programs will seek innovative ways to reach student learning outcomes.”⁵⁹ In addition to allowing nursing students in their senior year to work with a temporary license prior to graduation, Idaho created a new nurse apprentice program to allow “nursing students [to] perform functions as unlicensed assistive personnel” in which their employers would determine their scope of practice based on each apprentice’s training and skills.⁶⁰

Several states significantly expanded scopes of practice for various clinicians. Of the 28 states that prohibit NPs from practicing independently, 5 (Kentucky, Louisiana, New Jersey, New York, and Wisconsin) completely suspended such barriers, and 16 partially suspended them. Many of these suspensions expanded NPs’ authority to write prescriptions.⁶¹ New Jersey Gov. Philip D. Murphy, a Democrat who suspended his state’s restrictions on advanced practice nurses and physician assistants practicing independently, those clinicians prescribing controlled substances, and the tasks physician assistants may perform in operating rooms, wrote:

It is in the public interest to expand the scope of practice of those health care professionals who under current law practice with individualized physician oversight, so that they can be deployed to meet the anticipated needs with more autonomy, greater agility, and with all

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necessary tools, including independent authority to prescribe controlled dangerous substances when appropriate.⁶²

New York expanded scopes of practice to let nurse anesthetists, physician assistants, and specialist assistants practice independently; to let pharmacy technicians help pharmacists compound, prepare, label, and dispense drugs for home infusion providers; and to increase the number of providers who can supervise emergency medical services personnel.⁶³ Alabama expanded scopes of practice for NPs, nurse midwives, nurse anesthetists, physician assistants, and anesthesia assistants, freeing them to “practice to the full scope of their practice as determined by their education, training, and current national certification(s).”⁶⁴ Colorado expanded scopes of practice for a host of health professionals (podiatrists, optometrists, chiropractors, veterinarians, dentists, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, surgical assistants, surgical technologists, volunteer retired nurses, and nurse aides) as well as (unlicensed) nursing students and medical assistants by allowing NPs and nurse anesthetists to delegate tasks to them.⁶⁵ States including California, Maryland, and North Dakota allowed pharmacists to order and collect specimens for COVID-19 tests.⁶⁶ States including Florida and Nebraska expanded scopes of practice for emergency medical technicians.⁶⁷ Massachusetts Gov. Charlie Baker, a Republican, suspended that state’s physician-supervision requirements and restrictions on prescriptive authority for advanced practice nurses with more than two years of experience.⁶⁸ Michigan Gov. Gretchen Whitmer, a Democrat, suspended the state’s licensing laws to allow all hospitals, nursing homes, surgical centers, hospice practices and facilities, emergency or other medical transport companies, and other health care facilities to ignore Michigan’s licensing, scope of practice, and physician-supervision restrictions and decide for themselves how to use every health professional and student, paid or volunteer,

that they can find.⁶⁹ Maryland implemented a similar waiver with respect to health care facilities.⁷⁰ Whitmer explicitly suspended physician-supervision requirements for NPs and physician assistants and allowed RNs and licensed practical nurses to order COVID-19 tests.⁷¹

States took other steps that did not directly affect right-skilling but removed other barriers to care that licensing creates. Most states—including New Jersey and New York—suspended prohibitions on clinicians in other states providing care to their residents, whether in person or via telemedicine, either outright or by way of conditional waivers that require registration or an emergency license.⁷² Several states removed barriers to clinicians providing care after they retired or otherwise allowed their licenses to lapse.⁷³ A few states temporarily reduced the barriers to entry for doctors already licensed in foreign countries. New Jersey’s Gov. Murphy allowed such doctors to practice in that state without a license if they had practiced in other countries within the past five years and worked in clinics or hospitals for at least five years.⁷⁴ New York and Massachusetts did not suspend their requirements that foreign-trained doctors obtain licenses from those states. But Massachusetts’s Gov. Baker, a Republican, and New York Gov. Andrew Cuomo, a Democrat, issued executive orders that reduced for such doctors the number of required years of graduate medical education to two years and one year, respectively.⁷⁵

Incumbent clinicians resisted the removal of barriers to right-skilling. Virginia Gov. Ralph Northam, a Democrat, temporarily allowed out-of-state NPs to practice in Virginia and suspended physician-supervision requirements for NPs who have more than two years of clinical experience. The Medical Society of Virginia—which lobbies on behalf of Virginia physicians—complained that Northam did not consult them before “needlessly” taking these steps.⁷⁶ The organization asked Northam to protect physicians from competition by allowing the waivers to expire, to subsidize

physicians, and to provide physicians protection from malpractice liability.⁷⁷

California's physician lobby loomed large over that state's pandemic response. The Healthforce Center at the University of California, San Francisco recommended the state expand its health sector capacity by letting NPs and nurse midwives practice independently; allowing hospitals to grant those nurses admitting privileges; and expanding the scopes of practice of certified nursing assistants, licensed vocational nurses, clinical nurse specialists, phlebotomists, medical laboratory technicians, clinical laboratory scientists, and paramedics.⁷⁸ Instead, California Gov. Gavin Newsom, a Democrat, delegated such questions to executive-branch agencies. The state's Department of Consumer Affairs refused to allow NPs to practice independently and instead increased the number of NPs each physician could supervise. Critics argued that the change would have little effect. "It's unclear how this is helping anybody," said Garrett Chan, CEO of HealthImpact, which advocates for a broader role for nurses in delivering care.⁷⁹ Unlike states that took the initiative to expand scopes of practice for emergency medical personnel, California's Emergency Medical Services Authority merely agreed to entertain such proposals from localities.⁸⁰ Critics attribute California's relatively tepid measures to the influence of the state's physician lobby, which "contributed almost \$6 million to candidates, political action committees, and other campaigns since mid-January 2019."⁸¹

State government responses to COVID-19 mirror temporary removals of barriers to right-skilling that governments have implemented during past pandemics. During the 1918 influenza epidemic, Spain sent medical students to practice in towns that lacked physicians.⁸² In 2009, many U.S. states responded to the H1N1 influenza outbreak by removing barriers to pharmacists, emergency medical technicians, dental hygienists, medical and nursing students, veterinarians, and other clinicians administering vaccines.⁸³ Some states have shown an increasing willingness

to suspend scope-of-practice restrictions to cope with predictable disease outbreaks.⁸⁴ In response to the 2013 and 2018 flu seasons, for example, New York's Gov. Cuomo issued executive orders removing barriers to pharmacists administering flu vaccines.⁸⁵

When public health crises become widespread enough, policymakers readily acknowledge that clinician licensing creates barriers to health care and suspend or discard many of those barriers—sometimes without so much as a nod to the incumbent clinicians who advocate maintaining them. When the public health crises end, however, incumbent clinicians again have their way. The scope-of-practice waivers that states implemented in response to Hurricane Katrina, the H1N1 flu outbreak, the 2013 and 2018 flu seasons, and other public health emergencies expired when those emergencies ended.⁸⁶ The barriers to care returned, even though many individual health crises remained.

AN ALTERNATIVE: FLEXIBLE EDUCATION AND CREDENTIALING

A system of third-party certification could deliver lasting reform by insulating such decisions from political influence by incumbent clinicians. Such a system could allow innovative alternative career paths and paths to clinician certification, reduce unnecessary training requirements, and reduce the cost of most health care services.⁸⁷

In such a system, states would not directly license individual clinicians, determine which clinician categories could exist, or delineate scopes of practice. Instead, states would rely upon third-party private and public organizations to accredit education, training, and certification programs that would perform these functions. To identify reliable accrediting organizations, states could piggyback on the efforts of the Department of Education and the Council for Higher Education Accreditation. Each engages in periodic reviews of organizations that accredit institutions and programs

“A system of third-party certification could deliver lasting reform by insulating such decisions from political influence by incumbent clinicians.”

“In contrast to today’s monopolistic, incumbent-controlled approach, a competitive system would free clinicians and (liable) employers to rely on programs that right-skill health services.”

of higher education in the United States.⁸⁸ In addition, states could rely on the National Commission for Certifying Agencies (NCCA) and similar organizations that may arise to accredit nonacademic credential programs. For example, the NCCA accredits specialty certification organizations such as the Oncology Nursing Certification Corporation, which offers certificates that attest to specific knowledge related to the treatment of cancer patients.

Degree- or certificate-issuing organizations would determine the categories of clinicians they would certify, including new categories (e.g., dental therapists, primary care technicians, community paramedics, and assistant physicians), and the education requirements and scopes of practice for each category. Today, “most health workforce models have taken a silo-based approach that assumes that each health profession has an exclusive and fixed scope of practice.”⁸⁹ In a system with greater flexibility, innovative programs would add new categories of clinicians, offer clinicians an option to expand their scopes of practice incrementally, support non-traditional career paths that rely less on formal education and more on demonstrated clinical competence, or offer quicker and affordable paths for immigrant physicians to practice. The number and shape of such programs would depend on demand from patients, clinicians, and clinicians’ employers.

In addition to verifying credentials, states could choose to maintain lists of all health care workers practicing in the state, indicating their certified scopes of practice. Alternatively, states could use various tools to make clinicians’ credentials accessible to employers and consumers. Options include Credential Engine’s planned online Credential Registry or similar services.⁹⁰ Blockchain technology, such as the Learning Machine credential-verification system that the Federation of State Medical Boards uses, can provide state agencies, employers, and patients with secure, immediately verifiable access to a clinician’s certifications.⁹¹ Employers could use those resources to screen applicants based on their training, experience, and credentials. Adding a “verified” symbol

to a clinician’s record could demonstrate that the clinician has various credentials, malpractice insurance, or hospital privileges or that the clinician belongs to particular health insurance networks. Malpractice insurance and hospital privileges would indicate that competent and legally liable entities have also evaluated clinicians and the organizations that certified their skills.

New educational programs would determine their own and often innovative methods for assessing relevant knowledge and skills. Certificate programs could choose to recognize prior clinical experience, such as that of military medics or emergency medical technicians.⁹² Some certification organizations might offer incremental or stackable credentials, allowing individuals to add skills as they progress in their careers.⁹³ Programs could train and credential entirely new classes of clinicians, offering new certificates for specific skills. These might include programs to train clinicians specifically to perform discrete procedures such as vasectomies, cataract surgery, and colonoscopies.

Unlike today, new categories of clinicians and new approaches to medical education would not encounter political obstacles on the path toward recognition. Recognition would move forward if employers, health insurance networks, malpractice insurers, and patients find a credential valuable and reliable. Clinicians could practice to the top of their training.

In contrast to today’s monopolistic, incumbent-controlled approach, which imposes unnecessary education and training requirements that reduce access to care, a competitive system would free clinicians and (liable) employers to rely on programs that right-skill health services. The potential for such competition would discourage accrediting organizations from either unnecessarily limiting entry or certifying clinicians with too little training.

Innovative Education and Certification

A shift from licensure to third-party certification could reshape health professions and health care for the better. Reformers have offered many ideas for streamlining medical

education; expanding scopes of practice for nonphysician clinicians; innovative alternative approaches to educating health professionals; and allowing clinicians to add to their knowledge and skills over time. Clinicians and academics have proposed establishing new categories of medical professionals.⁹⁴ The Blue Ribbon Commission for the Advancement of Osteopathic Medical Education has proposed a competence-based “New Pathway” to address “inefficiencies inherent in traditional, time-based educational models.”⁹⁵ Health systems like Kaiser Permanente could develop systems of education and certification based on their patients’ needs.⁹⁶

Removing these decisions from the political process would permit these reforms to proceed simultaneously. The entities that make the rules governing clinicians’ scopes of practice would no longer be competitors who have a financial interest in unnecessarily limiting those scopes of practice. They would be institutions that face incentives to limit scopes of practice only when necessary to avoid harm to patients. Consumers would not have to pay the price for politically motivated limits on innovative ways to improve access to quality care.

Upward Mobility

Allowing education and training outside traditional paths would make it easier for clinicians to move up throughout their careers, acquire additional skills, and expand their scopes of practice incrementally.⁹⁷ Examples of this type of flexibility exist in nursing, yet even those are too few, too costly, and confined to working within the rigid health workforce rules that direct government licensing produces.

Under third-party certification, individuals interested in health care careers would have greater flexibility in how their careers progress. Individuals lacking resources to invest in a doctoral-level degree could take advantage of credential programs to enhance their skills and expand their scopes of practice over time. Degree- or certificate-issuing organizations could develop educational programs for veterans who want to enter the

civilian health professions. With new programs, foreign-trained clinicians could find improved access to employment.⁹⁸ Tools such as Credential Engine and Badgr could provide more information on career paths—and how much employers value different skills—for clinicians who want to add to their skill base.⁹⁹

Proof of Concept

A system of third-party clinician certification would build on what already works. Clinicians, employers, and even states already rely on third parties to certify educational programs and clinical competence. For example, physicians pursue specialty certification from the American Board of Medical Specialties’ member boards and the American Osteopathic Association’s specialty certifying boards. The National Commission on Certification of Physician Assistants offers specialty certificates for physician assistants in the areas of cardiovascular and thoracic surgery, emergency medicine, hospital medicine, nephrology, orthopedic surgery, pediatrics, and psychiatry. Each certificate requires specialty training, on-the-job experience, the recommendation of a physician, and a passing score on a specialty exam.¹⁰⁰ Similarly, private organizations certify RNs who practice in a wide range of specialties. Two examples include AIDS-certified RNs and certified pediatric nurses.¹⁰¹

Employers’ efforts to right-skill their workforces also offer an informal form of third-party certification. Employers routinely use point-of-care task assignment and on-the-job training, such as teaching RNs to place peripherally inserted central catheter lines.¹⁰² Thirty-eight states explicitly permit employers to determine the scope of practice for individual physician assistants based on the employer’s appraisal of each individual’s clinical knowledge and skills.¹⁰³ Licensing plays no role in those decisions. Employers face strong incentives to make careful scope-of-practice and right-skilling decisions because they are financially liable if something goes wrong.

States generally require applicants for advanced practice registered nurse licenses to

“Clinicians, employers, and even states already rely on third parties to certify educational programs and clinical competence.”

“Third-party certification would add to, not subtract from, existing protections.”

provide evidence of being board certified by a private specialty board in addition to holding a BSN.¹⁰⁴ The organizations that accredit those programs seek recognition from the Department of Education and the Council for Higher Education Accreditation.¹⁰⁵

WHAT ABOUT QUALITY?

Third-party certification would provide patients greater protection than direct government licensing for two reasons. The first and most important is greater access to care, particularly for low-income patients. Third-party certification would facilitate the development of new models of health care delivery, such as retail clinics staffed by midlevel clinicians, independent (even mobile) dental-therapist practices, fully integrated delivery systems, and other innovations we cannot foresee. A model that continuously reduces both the monetary and time costs of accessing health services offers greater protection than a system that continually increases those costs.

Second, third-party certification would add to, not subtract from, existing protections. Most patient protection comes not from government licensing but from clinicians' and employers' concern for their own reputations, voluntary certification by professional associations, the threat of liability for malpractice, credentialing and privileging by liable employers at the point of care, and oversight and guidance by medical professional liability insurers.¹⁰⁶ These forces create an extensive network of activities that do more to protect patients than licensing does:

- Health care providers, health insurance companies, and medical malpractice liability insurers routinely assess the education, training, and skills of the clinicians with whom they associate. Such efforts include background checks; verification of education, clinical training, examinations, and specialty board certification; verification of malpractice insurance coverage, including any coverage limits

that may signal a high-risk clinician or practice; and review of past disciplinary actions, including hospital sanctions, exclusion from Medicare or Medicaid, and malpractice claims and awards. Employers and insurers conduct such credentialing prior to initial association and again periodically. Hospitals and other employers use this information, as well as direct observation of a clinician's skills by a proctor, to grant practice privileges, which determine what tasks each clinician may perform.¹⁰⁷ Although state laws give physicians an unlimited scope of practice, hospitals limit the tasks that doctors perform, through the privileging process, to those for which the physician has the proper training and expertise.¹⁰⁸ Even if state laws allow NPs to perform vasectomies, individual hospitals may require them to receive additional training first. Whether from a desire to protect patients, their reputations, or themselves from liability, these organizations independently review the clinicians they hire or include in their networks, often relying on existing private certification mechanisms.

- Through the malpractice liability system, the government forces health care providers to compensate the patients they injure. The threat of medical malpractice liability—the threat that the government will shift to clinicians the cost of their negligence—directly pushes physicians to improve quality, including by avoiding areas of medicine where they are not competent to practice, to avoid being sued.
- Medical malpractice liability insurers use their knowledge and experience to help the providers that they insure to improve quality because higher-quality care means fewer payouts.¹⁰⁹ Insurers who issue such policies assess the risks associated with individual clinicians' practice patterns and provide guidance to physicians on how to improve the quality of care. They

charge high-risk physicians significantly higher premiums, which creates a direct financial incentive for physicians to improve quality.¹¹⁰ Malpractice insurers also have a strong incentive to prevent clinicians from providing services for which the clinicians do not have adequate training. They thus help hospitals and other employers delineate scopes of practice and determine how much training is necessary to perform certain services.

If state governments were to repeal clinician-licensing laws entirely, private markets and the malpractice system would continue to offer protection. Third-party certification would augment these protections that voluntary market mechanisms, including those of medical malpractice insurers, already provide.

Government licensing of clinicians offers patients little if any additional protection. The public and even intellectual elites harbor profound misunderstandings about how little protection clinician licensing offers. In 2014, for example, the U.S. Supreme Court reflected on the desirability of having physician members on state medical boards. During oral arguments, as the Justices discussed a proposal to have nonphysicians oversee state medical boards, Justice Stephen Breyer assumed that state medical boards decide who can practice brain surgery:

What the State says is: “We would like this group of brain surgeons to decide who can practice brain surgery in this State.” I don’t want a group of bureaucrats deciding that. I would like brain surgeons to decide that.¹¹¹

Justice Antonin Scalia agreed:

Really? You are going to have a review board composed of nonneurologists deciding . . . whether a particular person should be admitted or a particular rule should be adopted? . . . I don’t want that. I want a neurologist to decide it.¹¹²

Yet state medical boards do *not* decide which physicians are competent to conduct brain surgery.

State licensing boards grant a plenary, or unlimited, scope of practice to anyone who fulfills the minimum requirements for becoming a physician. They do not issue specialty-specific licenses or evaluate physicians for specialty-related training, skills, or experience. So far as state medical boards are concerned, anyone who graduates from an accredited medical school and passes a comprehensive exam may practice in any specialty and perform any medical procedure—including organ transplants or brain surgery—even if they have received no specialized training. What prevents unqualified physicians from performing brain surgery is not government licensing but the previously mentioned network of market-based patient protections—in particular, hospital credentialing and privileging—plus the medical malpractice liability system. Private credentialing and privileging efforts—and only these private efforts—separate physicians who are qualified to perform brain surgery from those who are not. At least two Supreme Court Justices assumed clinician licensing provides a protection that it does not, in fact, provide.

Indeed, licensing may contribute little, if anything, to quality-assurance efforts. When it comes to disciplining malfeasant clinicians, licensing boards are less vigilant than private-sector organizations, other government agencies, or the medical malpractice system. A 2011 study found that state medical boards disciplined less than half of the 5,887 physicians whose privileges hospitals had curtailed and *none* of the 220 physicians whom hospitals had deemed an “Immediate Threat to Health or Safety.”¹¹³ An investigation by the *Milwaukee Journal Sentinel* found that from 2013 through 2017, the Food and Drug Administration sent warning letters to 73 physicians in 28 states alleging they had violated federal patient-protection regulations but that only one of those physicians suffered any disciplinary action by a state medical

“Government licensing of clinicians offers patients little if any additional protection.”

“State medical boards disciplined less than half of the 5,887 physicians whose privileges hospitals had curtailed and none of the 220 physicians whom hospitals had deemed an ‘Immediate Threat to Health or Safety.’”

board.¹¹⁴ Another study found that among doctors who had made 10 or more medical malpractice payments, only a third faced any discipline by medical boards.¹¹⁵

Medical malpractice liability insurers aggressively search for indications that a physician may be low quality. Such insurers report that only one-quarter to a half of the physicians they identify as high risk have ever suffered disciplinary action by a state medical board.¹¹⁶ Even when medical boards do discipline physicians, they still fail to protect patients. The *Milwaukee Journal Sentinel* investigation found that “at least 500 physicians who have been publicly disciplined, chastised, or barred from practicing by one state medical board have been allowed to practice elsewhere with a clean license.”¹¹⁷ Out of 50 state medical boards, only one requires doctors to inform patients that they are on probation for misconduct.¹¹⁸ The fact that medical boards allow doctors that they know to have engaged in troubling behavior—from sex offenses to drug and alcohol abuse—to continue to treat patients points to the conclusion that clinician-licensing boards protect clinicians, not patients. One literature review summarizes:

Like many administrative agencies, medical boards are faulted for being subject to professional capture—a phenomenon where an industry protects itself rather than the community at large. . . .

Given that state medical boards’ stated purpose in responding to patient complaints is to protect the public from dangerous providers and ensure clinical competence, it is far from obvious that the current disciplinary system—which disciplines providers only infrequently, with limited levels of severity, for reasons that may not be related to clinical competence, and fails to communicate with complainants—actually achieves this goal.¹¹⁹

In a journal published by the Federation of State Medical Boards, patient-safety advocates

Lucian Leape and John Fromson conclude that medical boards take a “casual approach to monitoring physician performance” in part because they “typically do not define prevention of [patient] injury as part of their responsibility.”¹²⁰ And it is not just physician-licensing boards that fail to protect patients from their colleagues. One study found that nurses “rarely receive ‘reportable’ penalties for sexual misconduct” from boards of nursing.¹²¹

State licensing authorities cannot protect patients to the extent that these other quality-assurance mechanisms can. State medical boards issue licenses and respond to complaints. Even if they had authority and the incentive to do so, they could not possibly oversee all the hiring and task assignment decisions that employers and medical malpractice insurers make—decisions that are necessary to provide quality care to as many patients as possible.

Private-sector activities and the medical malpractice liability system offer so much protection that they make licensing efforts redundant. The fact that those efforts would continue to protect patients even if states repealed their clinician-licensing laws should reduce the temperature of debates over licensing reform and give states latitude to consider broad reform.

Finally, the same competitive and liability-generated forces that protect patients today would prevent third-party certifiers from adopting weak standards. Employers, malpractice insurers, and clinicians would look for credentials with established credibility. Third-party certification organizations would not survive unless they provide value to employers, health insurers, medical malpractice liability insurers, clinicians, and patients. If employers were to find, as they evaluate the knowledge and clinical skills of potential employees, that a specific certifying organization was doing a poor job in identifying clinicians for specific tasks, the credential would have little value. Registries such as Credential Engine could make information about the value of credentials readily available to all parties, strengthening incentives to assure quality.

Opponents of Reform

Incumbent clinicians reliably oppose any effort to right-skill the clinician workforce, whether by preventing competing professions from offering additional services they are competent to provide or by requiring entrants into their professions to comply with unnecessary educational requirements (e.g., liberal arts courses). Supporters of such requirements argue that allowing nonphysician clinicians to perform tasks traditionally performed by physicians would put patients at risk. They point to the years of education required of physicians, suggesting that anyone with fewer years of training is unlikely to be sufficiently competent.¹²² They rely on physician testimony, based on physicians' expectations, fears, or anecdotal experiences about the potential role of nonphysician clinicians.

The evidence tells a different story. Only a handful of studies have found differences between care provided by physicians and care provided by midlevel clinicians practicing within their training.¹²³ The vast majority of research has found that when nonphysician clinicians receive training to perform tasks traditionally performed by physicians, they do just as well or better.¹²⁴

CONCLUSION

High prices for clinician services reduce access to health care. A recent examination of the causes of relatively high health care spending in the United States concluded that during the period studied,

the United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. *Prices of labor* and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries.¹²⁵

An important component of prices for health services is the cost of education and certification of health professionals.¹²⁶

Decisions about how to constitute and reform the health care workforce should consider only whether the benefits to patients of a given approach outweigh the costs. The financial interests of incumbent clinicians, who may lose market share to competing clinicians, should not enter the equation.

Direct government licensing of clinicians guarantees the financial interests of incumbent clinicians will dominate the health and economic interests of patients. Third-party certification of clinicians would remove such matters from political influence and protect patients via enhanced access to care and a better guarantee of quality.

Third-party certification would benefit both patients and clinicians. It would offer patients more convenient access to a broader range of health services at a lower cost. It would provide clinicians greater economic mobility and flexibility in how they shape their careers. Individuals lacking resources to invest in upfront education and training could take advantage of credential programs to enhance their scopes of practice over time. The FTC and other policymakers are taking steps to reduce the labor-market barriers that occupational licensing creates. To date, these efforts have ignored the barriers that licensing imposes between patients and competent health professionals.¹²⁷ That must change. Whether policymakers are unaware of the negative effect licensing has on access to health services, the tenuous connection between licensing and quality, or the prevalence of third-party certification, or whether policymakers believe incumbent clinicians are too politically powerful to challenge, direct government licensing of clinicians is too harmful to ignore.

If one good thing could come of the COVID-19 pandemic, it should be broader acceptance of health workforce reform. Changing circumstances could shift the political equilibrium and make politicians open to options they have rejected in the past.

“If one good thing could come of the COVID-19 pandemic, it should be broader acceptance of health workforce reform.”

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