It is Time to Overhaul the American Physician Licensing System

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In the field of healthcare, most of the public policy discussions have been focused on demand-side solutions. The political left of our country has been agitating for decades in favor of a single-payer healthcare system, most recently floating proposals like Medicare for All. The political right, meanwhile, has put forth proposals to enhance competition and consumer choice in healthcare by introducing programs like Medicare Advantage and Health Savings Accounts (HSAs). In either case, the approach is to focus on how patients demand—i.e., access, receive, and pay for—healthcare goods and services.

While demand-side reforms are important, there are even more impactful changes on the supply side that could revolutionize the field of healthcare. One underappreciated solution is overhauling our physician licensing system, a regime that harms qualified medical professionals, impedes consumer choice and autonomy, and does little to ensure the quality of health services. By repealing physician licensing altogether—or at least removing the most harmful hurdles to licensing—we can increase the quality, access, and choice of healthcare in America.

Let's examine why, as currently designed, physician licensing does more harm than good for our healthcare system.

First, stringent licensing denies qualified health professionals the ability to practice. To obtain a medical license, which all 50 states require in order to practice, prospective doctors must go through four years of undergraduate education, four years of medical school, another two years or more in an approved residency program, and then pass a series of complex examinations. This is a laborious process to say the least.

In the education stage, all medical schools must be accredited by the Liaison Committee on Medical Education (LCME), which is jointly sponsored (and thus influenced) by the American Medical Association, an organization described as the world's last medieval guild. Like a guild in Adam Smith's age, the AMA through its influence over the LCME restricts entry into a profession, in this case by controlling the number of accredited medical schools. Apart from medical school, our current system also restricts the number of residency positions available. In fact, more than 2,500 of the 40,000 annual medical school graduates end up without a residency position, meaning that they must either wait for another year or give up the chance to practice what they have hitherto spent their life learning. Individual states also restrict doctors holding

licenses from other states or other countries from practicing freely. All these restrictions deprive qualified medical professionals of the opportunity to practice medicine.

Not only does our current licensing system obstruct prospective doctors, it also harms patients. Because there are not enough physicians, healthcare consumers, particularly those in rural areas, face increased prices and less access to care. According to MedPAC data published by KFF, a prominent health policy non-profit, from 2017 to 2023, 61 rural hospitals closed while only 11 opened, a significant cause of which is persistent staffing shortages in these hospitals.

More importantly, consumers lack the freedom to choose the medical service they desire under physician licensing. Consumers ought to be able to receive the medical care that they want without government interference. Without medical freedom, our system has fostered the existence of a healthcare black market where health services are illicitly rendered by unlicensed providers, an inevitable consequence of supply-restricting barriers.

Physician licensing does little to ensure the quality of care and could actually achieve the opposite effect. For employed physicians at least, the main factor ensuring the quality of care is credentialing. Both hospitals and medical malpractice insurers spend great time and effort verifying the education, training, and experience of the doctors they are hiring or insuring, and for good reason. An NIH study shows that credentialing alone lowers the number of patient safety events by up to 25%.1 Hospitals and medical malpractice insurers are incentivized to pay great attention to credentialing because they are bearing the cost of adverse medical events. These private and voluntary quality verification methods show that quality can be ensured without government involvement.

Licensing also changes the economic calculus of whether high achieving students would join the medical profession in the first place, which may actually lower quality of care. Talented undergraduate students can often succeed in multiple different fields. The prospect of four long years in medical school and then more than two years in residency, however, deters many high-achieving students from joining the medical profession. In a free market, those who want to pursue a four-year medical school can, while those who believe that they can succeed with shorter school can do so as well. Since licensing disincentivizes the most talented learners from becoming doctors, the policy might actually be a net negative on quality of care itself.

Physician licensing is a complex issue with many supply-restricting hurdles, but there are two simple policies that we can adopt to alleviate these problems.

First, Congress should pass the Resident Physician Shortage Reduction Act, a bill with bipartisan support in the House. This act expands residency positions that Medicare supports by 14,000 over seven years, which would meaningfully alleviate the residency backlog.

Second, individual states should recognize the medical licenses of all other states, which would allow doctors who hold those licenses to practice freely. 18 states have passed some form of Universal Licensure Recognition (ULR) laws that apply to physicians, with Arizona being the first to do so in 2019. 42 states have also joined the Interstate Medical Licensure Compact (IMLC), which meaningfully shortened wait times for physicians to acquire licenses in other states.

Both of these policies represent an overhaul that would increase the supply of medical care and offer more choice to the consumer. They should be options that are on the table. And, if we are bold enough, these options could help to create the conditions that would enable America to pursue a more comprehensive solution: abolishing medical licensure entirely. Individual states should no longer require a government issued license to practice medicine. This policy choice, while radical, will offer the most freedom to both medical professionals and patients. It would empower the market to regulate quality and competence through reputation and patient choice, shifting the focus from government oversight to consumer-driven accountability.

About the Author
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