Another Look at Licensure: Consumer Protection or Professional Protectionism?

Professional licensure represents state legislative action to define a profession, designate the parameters of practice, or affirm the professional competency of license holders (Shapiro, 1976). Efforts to obtain licensing at the state level have occupied the attention of allied health professional organizations for more than two decades. Frequently, national or state professional organizations initiate and manage campaigns to facilitate passage of legislation needed to establish state licensing bodies. The rationale most often cited by professional groups is the need for consumer protection.

Occupational therapists have been successful in obtaining passage of licensure laws in 46 states, the District of Columbia, and Puerto Rico. Although this may appear to be a cause for celebration, I believe that we also need to stop and consider what we as a profession provide and what we gain from state licensure laws. I am not opposed to the concept of state licensure. I am concerned, however, that occupational therapists as well as other professionals are perceived as benefiting from licensing acts without providing the consumer protection that justifies the legislation. Concerns have been voiced about the effectiveness of consumer protection measures and costs to consumers, both economically and in the form of restriction of consumer autonomy in the selection of health care providers. Nonmonetary costs to professional integrity must also be considered.

Although state licensing of self-employed persons such as physicians and dentists has been accepted practice since the latter part of the 19th century, it is only in the last few decades that professionals who usually function in the capacity of employees of health care facilities have actively sought and been granted state licenses (White, 1978). This movement has not engendered unconditional support. Existent and proposed legislation have come under the scrutiny of such government agencies as the Federal Trade Commission and the Department of Health, Education, and Welfare as well as groups and agencies concerned with accountability and consumer benefit (Shapiro, 1976).

That consumer protection from incompetent or unqualified health professionals is important is inarguable. The determination of how this can best be accomplished, however, is another matter. Questions are asked about the need for and the effectiveness and cost-benefit ratio of licensing at the state level. Other methods of credentialing are already at work before a state license comes into effect, for instance, accreditation of education programs and, for some professions, a national examination. Miller (1982) asked, “How many checks are needed to determine an individual’s abilities?” (p. 35). Additionally, these credentialing mechanisms offer a degree of uniformity that is absent with state licensing.

Wilma West reported in 1976 that evidence that consumer protection is served by licensing laws was not borne out by the research. Audet (1985) reported on a comparison of the performance of X-ray technologists in licensed and unlicensed states. This study, completed in 1976 by the American Society of Radiologic Technologists and the American College of Radiology, found “no definite differences in radiation protection practices between the licensure and the nonlicensure states” (Audet, 1985, p. 273).

Not only is there a lack of documentation of consumer protection, but also there is evidence of professional self-serving. Roemer (1980) stated, “In the opinion of many, licensing laws, originally designed to protect the public against quackery, commercial exploitation, deception, and professional incompetence, had failed to do so and instead protected professionals from too much competition” (p. 188). Miller (1982) quoted a member of a California state agency who noted that demands for licensing bills invariably come from professional groups rather than consumers demanding protection.

Stackpole (1978) acknowledged a component of professional self-interest in the licensing of respiratory therapists but insisted that consumer protection is the major emphasis. Miller (1982) also addressed the concerns of respiratory therapists who believed that licensing would assist them in receiving third-party reimbursement but who also contended “that their primary concern is quality of care” (p. 36).

There is ample evidence that professional licensure has acted instead to increase the costs of service to the consumer in several ways (Frey, 1984). Nichols (1989) pointed out that

Although licensing protects the public from incompetent and dishonest practitioners, it also restricts freedom of entry. This dual effect simultaneously protects the public and provides a basis for professional monopoly. (p. 65)
Education requirements for the attainment of licensure may increase costs of entering the profession that must be recouped through higher wages. White (1978) found that licensure laws requiring college degrees for laboratory work above the level of aide, by indirectly decreasing the supply of available laboratory workers, led to an approximately 16% increase in wages. Administrative costs for conducting licensing examinations and maintaining records on licensees as well as processing complaints are paid either through increased taxes or through direct license fees charged to members of the licensed profession. These costs are passed on to consumers as a part of fee for service.

Consumers frequently do not recognize monetary costs arising from licensure of health care professionals. White (1978) illustrated this through an example of laboratory test costs. Most laboratory tests are paid for by insurance. Because consumers do not pay for tests directly, "increases in the prices of tests due to licensure are not likely to have a significant impact on the final demand for tests or the derived demand for 'hospital personnel'" (p. 96).

Additionally, state licensing laws impose restrictions on specific tasks and functions and thus serve to increase costs by limiting flexibility of personnel assignments. Davy and Peters (1982) stated, American Occupational Therapy Association surveys conducted indicate no appreciable differences between the cost of occupational therapy services in states that have licensure laws and states without licensure laws. These findings came as no surprise because occupational therapy licensure laws did not increase the requirements to be an occupational therapist. (p. 430)

What Davy and Peters failed to consider, however, is that by more strictly defining occupational roles, the costs of specific services deemed to be occupational therapy may be higher in licensed states than in those states without licensure where the same service might be performed by someone other than an occupational therapist.

There are nonmonetary costs to consumers as well in the loss of autonomy in the choice of a health care provider. Hazlekind and Christoffel (1984) maintained that "underlying the principle of licensure is the assumption that the public cannot judge whether practitioners of the licensed professions are qualified or competent" (p. 105). Because, as Beauchamp and Childress (1983) pointed out, "the health care professional sometimes has a conception of benefits, harms, and their balance that differs from that of the patient" (p. 188), paternalism has long been a part of health care tradition. Beauchamp and Childress further stated, "To the extent one protects a person from harms produced by causes beyond the person's knowledge and control, the intervention has plausible claim to being morally justified, for the choices are substantially nonvoluntary" (p. 178).

In justifying professional paternalism, Davy and Peters (1982) concluded, "We believe the consumer is not in a position to evaluate the qualifications of an occupational therapist. Most consumers are not familiar with occupational therapy until they have an acute need for our services" (p. 430). The same is probably true of any of the allied health professions. Robert Atchley (1988), a gerontologist at Miami University in Ohio, stated, From the point of society at large, credentials and licenses are designed to differentiate people who have knowledge and experience in a field from those who do not. . . . The need for credentials and licenses stems from the fact that in the anonymous urban society, people can present themselves as being qualified whose performance subsequently indicates they are not—sometimes with catastrophic results. (p. 170)

Realistically, it is impossible to provide sufficient information on all allied health services to enable consumers to make informed choices. Besides the volume of information needed, the probability that the consumer will be uninterested in this type of information when not acutely in need of it precludes an effective public education campaign. Although this is adequate justification for a paternalistic intervention to benefit the consumer by protecting him or her from harm that might be done by an unqualified practitioner, it may be outweighed by the more than ample documentation of benefits for the licensed profession and costs to the consumer.

The licensing procedure also entails costs to the profession. A cost to professional honesty may derive from inability to establish that consumer protection is the foremost concern of professional groups seeking licensure. The practice of "grandfathering," or granting licenses to those engaged in an occupation at the time legislation goes into effect, can make no claim for consumer protection. It serves only to prevent opposition to passage of licensure legislation (Nichols, 1989).

Why, then, is consumer protection usually cited when professional groups seek licensure? Pragmatism, rather than deliberate dishonesty, is probably the cause. There are external pressures for licensure legislation that cannot be ignored. Hillbrath (1976) reported "a realization that existing federal and state laws favor licensed health professionals and that medical insurance tends more and more to cover only those services offered to consumers by licensed professionals" (p. 35). Professional groups in nonlicensated states have found that they lack legal definition and are vulnerable to usurpation of role by other professions gaining licensure. Winston (1976), in documenting the pursuit of licensure legislation by occupational therapists in New York, found that under New York State law (Title VIII of the Education Law), occupational therapy was not considered a profession. The importance of this became clear during the 1972–1973 legislative session, when a bill was introduced that permitted occupational therapists to work only under the supervision of psychologists. Occupational therapists, along with nurses and physicians, were not exempt from this bill, because, lacking the legal definition provided by licensure, they were not considered professionals by the State of New York.

The imposition of such external forces puts allied health professions in the position of taking action in order to survive, even if such action seems contrary to consumer interests. This is justifiable if we believe that the consumer ultimately benefits from the availability of the discipline. This benefit must be of sufficient magnitude to justify increased economic costs to the consumer to ensure the survival and availability of the profession's services.

Perhaps another factor is the prohibition on advertising and public announcements of costs of service, which were traditionally a part of professional codes of ethics (Gaumer, 1984). Al-
though the advertising of health care services is now common practice, lingering reservations may be responsible for what appears to be a less than candid rationale for licensure. Carson (1991) stated, “Professionals are expect-
ed to subordinate self-interest to the common interest in the health of the community” (p. 87). He further noted that “esteem diminishes when healers begin to look out for themselves first” (p. 87). Although Carson spoke to the esteem in which healers are held by society, there are implications for professional self-esteem. There may be further costs to professional integrity in terms of policing performance of members of the profession. As Stackpole (1978) pointed out, professional organizations control licensing boards. This puts them at risk for effectively dealing with disciplinary actions. Even though many license statutes require consumer representation on licensing boards, the persons ap-pointed must have some interest in the profession. The appointment process may mask the role of the professional organization in identifying consumers to be selected, but it would be naive to believe that state officials who make appointments do so without input from those concerned.

Although licensing of allied health professionals may seem to have fallen short of stated intent and, in many instances, seems to increase consumer costs without documented corresponding benefits, this is a somewhat simplistic and misleading appraisal. It is easier to quantify the negative aspects of licensing in economic terms than to do so with any positive features. It is difficult, if not impossible, to place economic value on the safety inherent in being treated by a practitioner with at least minimum competency. Even a title act provides some protection in that a person cannot publicly refer to himself or herself as a practitioner of a profession without minimum qualifications. There is in calculable, if unrecognized, value to the consumer in the assurance that an identified health care professional has met some minimum standards of preparation for practice. The consumer is relieved of the necessity of gathering information on the provider’s competency.

Carson (1991) identified three characteristics of a profession: “Demonstrated mastery of a branch of knowl-edge, the use of that knowledge in the service of society and its members, and self-regulation of professional conduct” (p. 87). Licensure laws can be the means by which these characteristics are sustained in practice. Creden-tialing mechanisms must be sufficiently rigorous to demonstrate acquisition of a minimum body of knowledge. A major complaint against licensing laws has been that they “generally regulated only initial qualifications to practice” (Roemer, 1980, p. 183). To improve consumer protection, a number of states and professions considered inclusion of credentialing mechanisms in their licensing laws. The intent of such modifications to licensing laws was to “remove those practitioners who are no longer competent to practice or place those practitioners on probation until they have regained the necessary competencies” (Gray, 1984, p. 23).

More importantly, we must provide public documentation of our commit-ment to quality care. We cannot rely on unsubstantiated claims of consumer protection and benefit; there is too much evidence to the contrary. Through both professional groups and state licensing agencies, we have the potential to monitor and document successful consumer protection. Our enforcement must concentrate not only on preventing nonoccupational therapists from claiming to practice occupational therapy, but also on weeding out incompetent practitioners from our own ranks.

Vigorous investigation and enforce-ment must be documented and publicized. We cannot claim consumer protection without identifying for consumers those persons who act in ways that compromise care. The time for protecting the identity of the person against whom a complaint has been lodged is prior to hearings or board actions. This is consistent with principles of due process in our legal system. We are obligated, however, to publicize the findings of hearings when a therapist is found to be in violation.

There is no reason to pass licensing laws if funding for licensing agencies is not sufficient to permit investigation of complaints and action against incompetent practitioners. Practitioners must be willing to pay licensing fees that are sufficient to provide funds for investiga-
tion and enforcement of regulations. Although such funding may add to health care costs, rigorous enforcement is necessary if licensing laws are to have the desired effect of assuring consumers of competent practitioners. Inadequate funding actually results in waste.

It is more equitable to have the costs of licensing health care professionals borne by all, that is, potential as well as current consumers, by tax revenues. However, as White (1979) pointed out, the general public is most likely to organize to resist tax increases. Politicians and policymakers exhibit more concern about direct government expenditure for licensing than about broader economic effects, such as costs indirectly passed on to consumers. This makes it all the more necessary for occupational therapists to publicly docu-ment the benefits of the expenditure of funds for self-policing. Efforts to repeal licensing acts on the basis of their lack of effective consumer protection can occur in any state (Lynch, 1988).

We need not apologize for the benefits that our profession accrues from licensing laws. We have valuable services to offer. If our continued existence depends on legal definitions afforded by licensing laws, so be it. However, our professional obligation must extend beyond the provision of quality care in our own practices to support for the consumer protection practices of our regulatory agencies. This support may be in any of several forms: willingness to pay licensing fees that are ade-quate to fund investigations and inter-ventions, willingness to assist with investigative procedures, attention to the activities of state legislators, and insistence that information on violations of licensing regulations be made available to the public. ▲

References

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