

**OCCUPATIONAL LICENSURE:
FROM BARBERS TO ACCOUNTANTS AND PHYSICIANS,
INFLUENCES ON PROFESSIONAL PRACTICE
IN THE UNITED STATES**

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Abstract

This paper examines mandatory occupational licensure in several professions from barbers, cosmetologists, radiologic technicians, CPAs, mid-level healthcare providers, and physicians. Mandatory licensure is cited as a mechanism for serving the public interest by assuring professionals possess the requisite knowledge, skill, and competence to provide safe high quality services. Mandatory licensure also creates barriers to entry in the profession, decreases market supply, increases wages, restricts mobility, and limits consumer choice and accessibility to services. Alternative mechanisms for assuring professional competency include the use of brand names, endorsements by professional organizations, and third-party certification. Brand names play an important role in consumer choice. Those entities that have built a strong brand name associated with high quality and trustworthiness have strong incentives to maintain high levels of knowledge, skill, and competence without regulatory oversight. Endorsements by reputable non-regulatory associations such as the AMA or the AICPA which require members to demonstrated defines standards of professional practice can serve as an important source of

information about practitioner competence and aid in the consumer decision-making process. Non-governmental third party entities such as *Consumer Reports* or *U.S. News and World Reports* are highly respected and utilized certifiers of competency and quality. In the absence of mandatory licensure, other credible third-party certifying institutions would rise up and provide unbiased assessments of the services provided by professionals. There are effective alternatives to mandatory licensing that service the public interest with fewer barriers to occupational practice and greater choice and less cost to the consumer.

INTRODUCTION

Occupational licensing has its origins in the medieval guild system of professional and trade crafts (e.g., lawyers, silversmiths, accountants, and barbers) (Rottenberg, 1962; Van Wyhe, 2007; Young, 1987). Entry into a guild craft often required completion of a training program or apprenticeship and legal permission by local, regional, or state authorities to practice the trade (Potts, 2009). Remnants of the guild system are still evident in modern day mandatory licensure laws.

Strong proponents for mandatory licensing argue that licensing serves the public interest by assuring practitioners possess the requisite knowledge and skill to provide safe and high quality services in their occupations. However, since the founding of the United States, economists have made cases against licensing by providing evidence demonstrating that mandatory licensing results in barriers to entry into the profession, increased wages for licensed professionals compared to the unlicensed, restricted mobility, and limited accessibility to services (Carpenter & Hock, 2008; Carroll & Gaston, 1981; Friedman, 1962; Gelhorn, 1976; Kleiner, 2000, 2005; Kleiner & Krueger, 2009; Shapiro, 1986; Shepard, 1978; Smith, 1937/1776; Young, 1987).

THREE FORMS OF OCCUPATIONAL AUTHORIZATION

There are three forms of occupational authorization to practice in the United States: registration, certification, and licensure. Over 1,100 occupations require registration, certification, or licensure in at least one state (Brinegar & Schmitt, 1992; Kleiner & Krueger, 2009; Summers, 2007).

Registration is the least restrictive form of professional authorization and imposes no education, training, or scope of practice requirements on the worker (Kleiner & Krueger, 2009). Typically the applicant is required to fill out one's name, address, and professional qualifications to practice in a specified trade with the appropriate governmental agency, and to pay a bond and/or application filing fee (Kleiner & Krueger, 2009, 2010).

Certification or "right to practice" is a method of assuring that professionals have the requisite skills and training to practice in a specific occupation (Kleiner & Krueger, 2009). Unlike mandatory licensure, certification does not restrict entry into the profession but serves the public by providing the consumer with information about practitioner qualifications and training (Kleiner & Krueger, 2009, 2010; Potts, 2009). Certification requires submission of evidence indicating completion of a set of education, training, and practice standards but does not require licensure to practice (Kleiner & Krueger, 2009, 2010; Potts, 2009).

Professionals applying for certification typically complete an examination administered by a private or public entity (often state or federal government agency) and pass a background check to verify submitted qualifications (Kleiner & Krueger, 2009, 2010). Those who pass the examination are certified as holding a specified standard of education, knowledge, and skill relative to the occupation for which they are seeking certification and are allowed legally to designate themselves as certified in their respective professions (Kleiner & Krueger, 2010).

Mandatory licensing involves the organization and control of occupations through mechanisms of the law (Potts, 2009). Licensure limits the right to practice to those meeting regulatory requirements (often defined by local, state, or federal governmental

agencies) (Kleiner & Krueger, 2009). Any individual not holding such licensure is legally barred from practicing and receiving compensation for services provided in that occupation (Kleiner & Krueger, 2010). Most occupational licensure is granted at the state level (Kleiner & Krueger, 2010). According to Rottenberg (1980), state licensure laws were created to define the scope of practice for occupations, describe the requirements for obtaining licensure, and limit practice of the occupation only to those whom the state has conferred a license. Interestingly, some occupations (e.g., electricians) require licensure in some states but not in others (Kleiner & Krueger, 2010).

Generally, occupations with longer periods of educational preparation require licensure. Kleiner and Krueger (2010) reported that more than 40% of those in occupations requiring post-graduate education (e.g., lawyers, accountants, and physicians) are required to be licensed to practice while only 11% of workers in occupations requiring a high school degree or less must be licensed (e.g., barbers, cosmetologists, and radiologic technicians) (Adams, Ekelund, & Jackson, 2002; Kleiner & Krueger, 2010; Timmons & Thornton, 2010).

During the 20th century, the number of occupations requiring professional licensure increased steadily (Kleiner, 2006; Timmons & Thornton, 2010). Between 1950 and 2000, the percentage of workers in the U.S. that needed state licensure to practice their trades rose from less than 4.5% (Rottenberg, 1962) to 18% (Kleiner, 2000; Kleiner & Krueger, 2009, 2010). Approximately 25% of workers must be fully licensed and 35% must hold a local, state, or federal agency granted license in order to work for pay in their current job (Kleiner & Krueger, 2008, 2009, 2010). Workers belonging to unions and those working for government agencies typically have a higher percent of licensed employees compared to private sector or non-union workers (Kleiner & Krueger, 2010). The rise in occupations with mandatory licensure coincided with the shift from industrial to post-industrial economies and the resultant decrease in

manufacturing and increase in service oriented occupations (Kleiner & Krueger, 2008; Potts, 2009).

LICENSING: FROM BARBERS TO ACCOUNTANTS

Mandatory licensing is required along a continuum of occupations that include barbers and cosmetologists, radiologic technicians, mid-level clinicians (e.g., midwives, nurse practitioners, and physician assistants), physicians, and certified public accountants (Adams et al., 2002; Aghimien & Fred, 2010; Holcombe, 2003; Kleiner & Krueger, 2010; Svorney, 2008; Timmons & Thornton, 2008, 2010).

Barbers

Barbers were one of the first occupational groups to be licensed in the United States with the first barber license laws passed in Minnesota in 1897 (Thornton & Weintraub, 1979; Timmons & Thornton, 2010). Barbers are predominantly self-employed, male, and serve a male clientele (Timmons & Thornton, 2010). To increase wages and improve the barbering occupation, the Associated Master Barbers of America was formed in the 1920s (Timmons & Thornton, 2010). Barbers lobbied for mandatory licensing as a means of driving low-cost barbers and poor quality “quickie” barbering schools out of business. When this did not work, the focus then turned to improving the training and quality of services provided by barbers (Timmons & Thornton, 2010). Barbering associations pushed for mandatory licensing arguing that licensing would improve the practice of barbering due to the rise of unsanitary conditions in shops, poor training, and poor quality services by incompetent barbers (Thornton & Weintraub, 1979; Timmons & Thornton, 2010).

Most licensure requirements for barbers include completion of an approved barber school (ranging from 1,000 to 2,100 hours of instruction) or apprenticeship (average length just under 3,000 hours) as well as passing a practical and written exam (Guarisco, 2005; Thornton & Weintraub, 1979; Timmons & Thornton, 2010).

Increasingly states are phasing out apprenticeship programs instead requiring completion of an approved barbering school training program. Overall, according to Timmons and Thornton (2010), barbering is one of the oldest professions requiring licensure and that many licensure requirements result in barriers to entry, decrease mobility, and significant wage earning potentials across states.

Cosmetologists

The tasks and functions of a cosmetologist are defined in the *Dictionary of Occupational Titles* by the U.S. Department of Labor, Employment and Training Administration (1977 as cited in Adams et al., 2002) as:

Providing beauty services for customers: Analyzes hair to ascertain condition of hair. Applies bleach, dye, or tint, using applicator or brush, to color customer's hair, first applying solution to portion of customer's skin to determine if customer is allergic to solution. Shampoos hair and scalp with water, liquid soap, dry powder, or egg, and rinses hair with vinegar, water, lemon, or prepared rinses among other services. (pp. 273-274)

Every state requires those applying for licensure to meet educational requirements ranging from completing at least the seventh grade to earning a GED or high school diploma, passing written and application sections of the licensure exam as well as completing a specified number of training hours (ranging from 1,00 to 2300 hours) (Adams et al., 2002).

Because the services provided by barbers and cosmetologists are very similar (cosmetologists cannot shave facial hair), seventeen states have merged their barber and cosmetology boards (Timmons & Thornton, 2010). While some states (Colorado, Connecticut, and Texas) have considered implementing sunset legislations to abolish barbering and cosmetology boards, only Alabama has abolished its barber licensing board (Kasper, 2007; Timmons & Thornton, 2010). Most barber/cosmetology licensing boards include one or more practicing barbers. Actions of

the boards typically include developing and enforcing sanitary regulations, standards practice, setting of education and training standards, and taking disciplinary action (Timmons & Thornton, 2010).

Radiologic Technicians

Radiological technicians are principally found working in the areas of radiography, radiation therapy, and nuclear medicine (Timmons & Thornton, 2008). The principle duties typically involve operation of radiological devices such as x-ray, MRI, and CT scanners to produce x-ray and other images as well as administer radiopharmaceuticals and radiation in the treatment of cancer (Timmons & Thornton, 2008). The majority of radiological technicians are women, more than 90% work for physicians, hospitals, imaging centers and 50% hold more than one credential (Timmons & Thornton, 2008).

Since the 1920s, voluntary certification as a radiologic technician has been granted to those who complete education and training requirements, pass an examination determined by the American Registry of Radiologic Technologists and complete continuing education requirements every 2 years (Timmons & Thornton, 2008). Radiological technician training does not require completion of a college degree; most states require completion of a minimum of a 2 year post-secondary vocational training program (Timmons & Thornton, 2008). Currently 35 states require mandatory licensing and several states are in the process of implementing licensure (Timmons & Thornton, 2008). Since the 1990s, there has been heavy lobbying to make licensure mandatory in all states (Timmons & Thornton, 2008).

Mid-Level Healthcare Clinicians

Mid-level clinicians include such occupations as optometrists, physical therapists, advanced nurse practitioners, nurse anesthetists, nurse mid-wives, podiatrists, and physician assistants (Svorney, 2008). By 2004, there were 240,000 advanced

practice nurses and 60,000 physician assistants working in the United States (Svorney, 2008). Mid-level clinicians such as nurse midwives and nurse anesthetists have provided services traditionally performed by physicians in the past (Svorney, 2008). Non-physician mid-level clinicians can provide quality care performing tasks once only included in the scope of practice for physicians (Allen, 2000; Svorney, 2008).

In recent years, scope of practice for non-physician mid-level clinicians has been expanded, however current licensing laws restrict the ability of mid-level clinicians to use the full extent of their knowledge and skills (Svorney, 2008). Physician groups against expanded scope of practice for mid-level clinicians have failed to find support in the research that mid-level clinician care results in poor medical outcomes (Svorney, 2008).

Physicians

Physicians and many other medical occupations are strictly regulated at the state level with licensure laws for physicians more uniform across states than other healthcare professions (Holcombe, 2003; Svorney, 2008). Licensure standards are set by the National Board of Medical Examiners; the board is comprised of licensed physicians (Holcombe, 2003).

In the early 20th century, states gave authority to physician licensing boards to administer licenses, sanction physicians, and revoke medical licenses (Holcombe, 2003; Svorney, 2008). State statutes dictate licensing standards and scope of practice (tasks that licensed professional are permitted to perform) with medical school accreditation authority given to the American Medical Association (Svorney, 2008).

Certified Public Accountants

Currently, state boards of accountancy have in place educational, experience, ethics, and national examination requirements that must be satisfied in order for accountants to practice legally in state and local jurisdictions as certified public accountants (CPAs). Typically CPA applicants must pass the

national CPA examination set by the American Institute of Certified Public Accountants (AICPA) and complete 150 semester hours of professional education and training (Aghimien & Fred, 2010).

As with most trades, accountancy in the United States once was taught through apprenticeships (Schaefer & Zimmer, 1995; Van Wyhe, 2007). As a means of elevating accounting as a professional occupation, during the 1880s accountants banded together and established membership organizations, notably, the Institute of Accountants and Bookkeepers in 1882 and the National Association of Public Accounts in 1887 (NAPA, precursor to the American Institute of Certified Public Accountants or AICPA) (Romeo & Kyj, 1996). Entry into these professional organizations was closely guarded and limited to those accountants whom members of the organization believed possessed the requisite level of good character and professional ability.

Increasingly the accounting occupation was viewed by states as a profession. State governments assumed a greater role in oversight of the profession by adopting licensing requirements for designation as a Certified Public Accountant (Van Wyhe, 2007). Currently there are 55 jurisdictions that administer accounting licensure laws and regulations (Crawford, 2011). Typically state jurisdictions have special commissions that develop minimum standards for licensure and empower state boards with oversight to develop and enforce disciplinary policies, set licensing standards, and administer codes of ethics (Schaefer & Zimmerman, 1995).

With the backing of accounting professional organizations, state governmental licensing requirements eventually included education, practical experience, ethical components, and passing the Uniform CPA exam (Van Wyhe, 2007). CPA candidates take the same Uniform CPA exam, however, education and experience requirements vary by state (Aghimien & Fred, 2010). While professional organizations cited the need to protect the public interest as the reason for increased licensure requirements, the underlying intent of these organizations was to elevate the accountancy profession status and stature on par with medicine and

law which required graduate level educational preparation and passing a comprehensive examination for licensure to practice (Van Wyhe, 2007).

Uniform CPA Licensure Exam. In 1886, New York was the first state to require passing a CPA exam for licensure and by the 1890s, membership in NAPA and other accounting professional organizations required applicants to pass a CPA exam (Romeo & Kyj, 1996). Other states soon followed suit and in 1917 the first national or Uniform CPA exam was administered by the AICPA to all CPA licensure candidates (Rueschloff, 1986). For decades, the Uniform CPA exam was 19.5 hours long and administered over a 2.5 day period. In 1994, the exam was shortened to 14 hours over two days (AICPA, 2010; Blum, 1991).

The Uniform CPA exam is presented only in English and covers four content areas in auditing and attestation, financial accounting and reporting, business law and ethics, and business environment and concepts (Aghimien & Fred, 2010; AICPA, 2010; Philipp, 2007; Roberts, 2006). Currently, the four sections of the exam can be taken separately but all sections must be passed within an 18-month window (Carpenter & Hock, 2008). Passage of the Uniform CPA exam is intended to provide the consumer with assurance of the quality of the education and training of accounting professionals and maintain a high quality pool of accountants (Schick, 1998). In 2008, the passing rate was 48.7% (Aghimien & Fred, 2010).

CPA Licensure Education Requirement. Beginning in the 1930s, states began to adopt educational requirements for licensure as a CPA (Schaefer & Zimmer, 1995). In 1938 New York was the first state to require a 4-year degree as a CPA licensure requirement (Schiff, 1980). During the 1950s to the present day, states have increased the educational component to include a 4-year degree and additional post-graduate level education (Siegel & Rigsby, 1989). The rationale for the long

education preparation has been that the increased education improves the quality of services provided, strengthen the public trust in CPA services, and increases CPA competence in areas such as accounting (cost, financial, managerial), auditing, business administration, economics, marketing, tax law, technology, and ethics ((Aghimien & Fred, 2010; Albrecht & Sack, 2000; Johnston, 2007; Schaefer & Zimmer, 1995).

In 1977, The Commission on Auditors' Responsibilities proposed an increase in educational requirements for CPA licensure to include a 4-year undergraduate degree followed by completion of a 3-year professional program (Schiff, 1980). Deans from schools offering accounting education programs viewed this increased educational requirement as premature and unnecessary. The deans cautioned that substantially increasing the educational component would serve as a barrier to entry into the profession because of the increased financial and opportunity costs, especially for the economically disadvantaged and those from minority groups (Schaefer & Zimmer, 1995; Schiff, 1980).

The minimum 7-year professional educational preparation program was not adopted; however, the AICPA in 1989 recommended states adopt the 150-hour rule mandating completion of a minimum of 150 credit hours of higher education prior to sitting for the Uniform CPA exam and as part of the overall licensure requirements (Aghimien & Fred, 2010; Carpenter & Hock, 2008; Carpenter & Stephenson, 2006; Van Wyhe, 2007). By 2011, all but eight jurisdictions had adopted the 150-hour rule (Mastracchio, Lively, & Carlson, 2011). However, the 150-hour rule does not necessarily attract better students into the profession because school standards for student admission and graduation vary widely (Schiff, 1980).

Meeting the 150-hour education requirement often entails completion of a bachelor degree plus additional post-graduate level courses (Aghimien & Fred, 2010). Critics of the 150-hour rule argue it creates a barrier to entry into the profession by requiring an additional year or more of formal education, thus increasing financial and opportunity costs and posing an economic hardship,

especially for those from minority groups (Albrecht & Sack, 2000; Carroll, 2005; Van Wyhe, 2007).

As of June 2009, 48 of 55 jurisdictions had adopted the 150-hour requirement (Carpenter & Hock, 2008). The 150-hour rule has been viewed as a mistake by critics for two primary reasons. First, the rule forces students to choose a specialty area too early during their educational preparation (Van Wyhe, 2007). Second, the rule imposes increased opportunity costs on new entrants that may not be justified by the return on investment and return on market value for the extra year of education and loss of earnings (Albrecht & Sack, 2000; Van Wyhe, 2007).

While a positive association between increased credit hours of study and an 18-20% increase in passing the Uniform CPA exam have been reported, also noted has been a steady decrease in the number of people enrolled in accounting programs of study and a decrease of 60.5% of those sitting for the exam between 1985 and 2002 (Albrecht & Sack, 2000; Allen & Woodland, 2006; Byrnes, 2000; Carpenter & Hock, 2008; Carpenter & Stephenson, 2006; Frieswick, 2000; Schroeder & Franz, 2004; Van Wyhe, 2007). The increased pass rate is explained in part by changes in how the exam is administered; the exam is divided into sections and candidates can take the test one section at a time, passing one section before moving on to others (Carpenter & Hock, 2008). However, fewer CPAs in the market decrease supply, increase demand and earnings, and raise fees paid by the consumer for accounting services (Carpenter & Stephenson, 2006; Schaefer & Zimmer, 1995; Schiff, 1980). Finally, as with physicians, once the CPA exam has been passed, there are no re-examinations to assess that competency in knowledge and skill has been maintained over time.

CPA Licensure Experience Requirement. While all CPA candidates must pass the same Uniform CPA exam, states have differing educational and experience requirements. The AICPA and the National Association of State Boards of Accountancy (NASBA) developed the Uniform Accountancy Act (UAA)

implemented in 1992 (Aghimien & Fred, 2010). The goal of the UAA was to establish a minimum level of one year of experience or the equivalent under the direction of a licensed professional (Aghimien & Fred, 2010).

Experience requirements for licensure range from no requirement (Puerto Rico), advanced education in lieu of experience, or up to a year of full-time experience obtained immediately preceding application for licensure (Aghimien & Fred, 2010; Becker Review, 2007). Experience can include: (a) work as a public accountant; (b) teaching experience in high level accounting discipline courses; and (c) non-public accounting experience from work in business, government, or non-profit organizations (Aghimien & Fred, 2010). Some states require candidates to pass the Uniform CPA exam and complete experience requirements before the CPA license is conferred (AICPA, 2010; Aghimien & Fred, 2010). Other states require candidates first to pass the Uniform CPA exam and become certified CPAs prior to fulfilling the experience requirement for licensure (Aghimien & Fred, 2010). Half of states require candidates pass an ethics exam once the CPA exam has been passed (Aghimien & Fred, 2010). Finally, CPAs are generally required to complete a specified number of continuing professional education annually to maintain licensure (typically 40 hours a year) (Aghimien & Fred, 2010).

Quality Peer Review. In 1977, the AICPA required members to establish a voluntary peer review system. Peer reviews were conducted by outside agencies and reports were submitted to the appropriate board of accountancy (Casterella, Jensen, & Knechel, 2009; Hein, 2008; Konrath, 1993; Schaefer & Zimmer, 1995). The peer review system was implemented as a means of improving the quality of services provided to the consumer by CPAs (Konrath, 1993; Schaefer & Zimmer, 1995). In 1988, the AICPA made quality peer reviews mandatory for member CPAs and firms that provided audit, reviews, attestation, and compilation

services of non-public entities (Casterella et al., 2009; Hein, 2008; Morrison & Shough, 2009).

The 2002 Sarbanes-Oxley Act resulted in the creation of the Public Company Accounting Oversight Board (PCAOB) that now requires public company auditors to submit to a peer review process under the AICPA Center for Public Company Audit Firms Peer Review Program (CPCAF PRP) (Gramling & Watson, 2009). As a means of strengthening audit quality, the CPCAF includes inspections of quality control systems that are not covered by the PCAOB peer review process (Gramling & Watson, 2009).

Beginning January 1, 2009 the AICPA implemented changes in the quality peer review process to increase transparency, clarity and understanding of review reports (Casterella et al., 2009; Hein, 2008; Loscalzo, 2010). In most states, CPA firms that fail to submit to the review process are barred from registering or registering with the state and lose membership in the AICPA (Barry, 2001; Gramling & Watson, 2009; McCrone, 2010). Some states exempt sole proprietor CPAs or firms with two or fewer CPAs while other states require peer review regardless of the size of the firm if that firm provides audit or attestation services (Barry, 2011).

Some states have created quality review oversight boards to monitor the peer review process and to take disciplinary or corrective action when warranted (Barry, 2011). Requiring firms to register with the oversight board and participate in the review process serves the public interest by providing assurance of professional competence to provide CPA services.

By 2012, 46 state boards of accountancy required quality peer reviews are part of the licensure retention requirement and the Government Accountability Office requires quality reviews for any firm doing work for a government entity (Graham, 2009). The rationale for the peer review requirement is to promote quality and accountability in accounting, auditing, and attestation services provided by CPAs and CPA firms (Casterella et al., 2009; Graham, 2009).

The implementation of the quality review process has improved levels of quality assurance among CPA firms and provides reliable information about the quality of services provided (Casterella et al., 2009; Morrison & Slough, 2009). The valuable information related to the competency and quality of services provided reported through the review process can be used by the general public in the decision-making process (Casterella et al., 2009).

The quality peer review process includes inspection every three years by an independent CPA reviewer of audits, financial statements, and the internal control system in place covering a one year period (Barry, 2011; Gramling & Watson, 2009; McCrone, 2010; Volz, 2011). Two types of reviews are conducted: system and engagement. A system review is conducted on those firms that perform audit and attestation services and engagement reviews are conducted on firms that conduct only reports, reviews, and compilation services (McCrone, 2010). Deficiencies that exceed a defined level of significance are noted in the inspection report (Gramling & Watson, 2009).

The final review process includes one of three grade categories indicating the degree the reviewed entity has met accounting and quality control system standards established by the AICPA for an accounting and audit practice: pass, pass with deficiencies, and fail (Gramling & Watson, 2009; Hein, 2008). A “pass” designation indicates that the system of quality control for accounting and auditing practices was suitably designed and implemented (Hein, 2008; McCrone, 2010). A “pass with deficiencies” designation indicates that some deficiencies were noted in one area of engagements or the quality control system but still suitably comply with required standards (Hein, 2008, Loscalzo, 2010; McCrone, 2010). A “fail” designation indicates deficiencies were found in all engagement areas or the quality control system was not suitably designed (McCrone, 2010). Part of the review report is a finding for further consideration (FFC) statement that reviewers use to make comments and recommendations related to the findings as a means of helping the reviewed entity rectify

deficiencies and improve performance in the future (Graham, 2009). In 2007, 2% of reviewed firms received a fail finding and 5% passed with deficiencies (Stoltz, 2009).

Quality review reports from members of the AICPA and some PCAOB review reports are made public (Graham, 2009; Gramling & Watson, 2009; Loscalzo, 2009). To facilitate transparency in the quality peer review process, the Facilitated State Board Access (FSBA) secure website was launched in 2009 by the AICPA (AICPA, 2008; Hein, 2008; Morrison & Shough, 2009). State boards of accountancy can access review reports of CPA entities practicing in their state and all firms that are members of the AICPA have report results posted to a public file (Graham, 2009; Gramling & Watson, 2009; Hein, 2008; Loscalzo, 2009).

The self-regulated peer review process is an effective means of assessing the quality of services provided. Eliminating mandatory licensure requirements and instituting a thorough quality review process would serve the public interest by providing publicly available information about CPAs and the services provided at reduced costs to the market and consumers (Casterella et al., 2009; Stigler, 1971). If a CPA or CPA firm has the “seal of approval” by membership associations such as the AICPA which participate in the quality peer review process, the need to mandate education, experience, and other requirements become unnecessary. If the CPA or CPA firm passes the review process, then levels of knowledge, experience, and competence have been demonstrated. This provides for knowledge and skill to be acquired through several different pathways from apprenticeships to formal education.

New IRS Restrictions on Tax preparation. In March 2012, the *Loving et al. v. IRS* (3/13/2012) class action lawsuit was filed in response to the new IRS mandated tax preparer licensing requirements (Circular No. 230, 31 C.F.R. part 10, revised 8-2011) that became effective August 2, 2012 (*Loving et al. v. IRS*, 3/13/2012, pars. 4, 28; *Loving et al. v. IRS*, 6/4/2012, par. 27). The new IRS licensing law gives an exemption to preparers employed

by an IRS recognized firm (typically law or CPA) and supervised by an IRS approved agent (typically attorney, CPA, or other approved agent) who signs the completed return (Loving et al. v. IRS, 2/13/2012, par. 49). This exemption does apply to registered tax preparers, preparers supervised by a registered tax preparer, or preparers employed by a firm that is at least 80% owned by a registered tax preparer (Loving et al. v. IRS, 3/13/2012, par. 50).

The basis of the lawsuit is that Congress has not empowered the IRS to license tax return preparers and that the new requirements are exempt for large tax preparation firms (e.g. Jackson Hewitt and H & R Block) giving them a competitive advantage over small independent tax preparer businesses (Loving et al. v. IRS, 3/13/2012, pars. 52-53). The new law is a re-interpretation of a nearly century old statute (31 U.S.C. §330) that had not been interpreted in the past to give the IRS the authority to regulate income tax preparers (Loving et al. v. IRS, 9/28/2012, p. 1). In fact, in 2005 the IRS made a statement that that Circular 230 (section 330) does not apply to tax return preparers because they do not represent individuals before the IRS (Loving et al. v. IRS, 9/28/2012, p. 19). According to IRS regulations, “A person may be a tax return preparer without regard to education qualifications and professional status requirements, 26 C.F.R. §301.7701-15(d)” (Loving et al. v. IRS, 9/28/12, p. 19).

The reason the IRS claims it is implementing the new requirements is to protect the public interest by assuring the competency of tax preparers. However, public protection measures already exist. Prior to the new IRS licensing law, the majority of tax preparers were not licensed by the IRS but were still subject to civil and criminal statutes governing tax preparation (Loving et al., v. IRS, 3/13/2012, pars. 12-13). Tax preparers are allowed to prepare and sign tax returns and refund claims (Loving et al. v. IRS, 3/13/2012, par. 35). Effective January 1, 2011, the new regulation requires all professional tax preparers to obtain a Preparer Tax Identification Number (PTIDN) from the IRS to be included on all tax returns to identify the preparer (Loving et al. v. IRS, 3/13/2012, par. 14). Obtaining the PTIN or renewal did not

require an examination or continuing education but required completion of an application and payment of \$64.25 yearly fee.

Under the new IRS rule, the approximately 350,000 tax preparers who are not attorneys, CPAs or other enrolled agent or actuary or supervised by such professions must become a registered tax return preparer (Loving et al. v. IRS, 3/13/2012, pars. 30, 47). The new licensing requirements include obtaining a PTIN by filing an application and paying a non-refundable fee as well as passing a 2.5 hour competency exam costing \$116 by December 31, 2012 (Loving et al. v. IRS, 3/13/2012, par. 32; Loving et al. v IRS, 9/28/2012, p. 9).

Beginning in 2012, renewal of the new registered tax preparer license requires payment of a renewal application fee, completion of 15 continuing education units from IRS approved providers within each registration year, (Loving et al. v. IRS, 3/13/2012, pars. 34, 38-39). Completion of the continuing education component would cost \$675 to \$1,012.50 per year (Loving et al. v. IRS, 3/13/2012, par. 46).

The new licensing requirements impose compliance costs that are difficult for 350,000 independent tax return preparers or small businesses to absorb and present a significant barrier to entry or continued operation within the competitive market (Loving et al. v. IRS, 3/13/2012, par. 29). To meet the new requirements, independent and small firm registered tax preparers would incur financial costs related to exam, education, and related food, travel, and lodging costs as well as opportunity costs for the time needed to fulfill the requirements. The costs of compliance will result in a decrease in supply of available tax preparers and registered tax preparers having to charge higher service fees or the exit the market.

Reciprocity. Until recently, different jurisdictional licensure requirements limited reciprocity or cross jurisdictional mobility, especially for individual CPAs or small CPA firms. Before mobility laws were enacted, out of state CPAs had to be

licensed in each jurisdiction in which business was conducted or had to apply for a temporary permit (Tampone, 2011).

The financial and opportunity cost for cross-mobility was especially burdensome to individuals and organizations that regularly transacted business across state and international boundaries (Aghimien & Fred, 2010; McGarry, 2005). In addition, the restricted mobility limited the supply of professionals available to consumers requiring cross-jurisdiction financial activities, thus reduced consumer choice (Aghimien & Fred, 2010; McGarry, 2002).

To make cross mobility more accessible, the AICPA and NASBA adopted the Uniform Accountability Act (UAA) to promote substantial equivalency in education, experience, and ethics licensure requirements (Voynich, 2007; Thomas, 2011). The intent was to make it easier for CPAs to meet the licensure requirements for multiple jurisdictions and thus remove barriers to obtaining temporary licensure or practice privileges. By 2011, 48 states had adopted some form of cross-mobility statute allowing for out-of-state practice privileges (Tampone, 2011; Thomas, 2011). While there are still financial and opportunity costs for conducting cross-jurisdiction financial activities, especially for independent and small firm CPAs, the adoption of cross-mobility statutes has helped to reduce barriers and increase consumer choice.

Barriers to Entry. With government involvement in regulating the accounting profession, the level of self-regulation within the profession has decreased, with the government assuming a significant level of regulatory control. This movement away from self to outside control over regulation typically results in increased barriers to entry due to higher financial and opportunity costs to meet licensure requirement, a decrease in the supply of labor driving up wages and earnings, and increased costs to the consumer relative to the benefits derived from increased licensing requirements (Carpenter & Stephenson, 2006; Van Wyhe, 2007).

Increased licensure requirements raise the cost of CPA services to the consumer. Holen (1965), Leffler (1978), White (1980), and Schaefer and Zimmer (1995) examined the relationship between licensure requirements and earnings within the accounting profession. States with education requirements beyond a 4-year degree and experience requirements are characterized by higher earnings for CPAs and higher fees for consumers (Schaefer & Zimmer, 1995).

Proponents for mandatory licensure of CPAs often cite the need to protect the public interest. While CPAs must provide evidence of completing a requisite number of continuing education hours each year in order to retain their licensure, there is no retesting requirement to assure the consumer that the CPA has retained an adequate level of knowledge and skill over time to provide competent service. In addition, though the AICPA passed the Uniform Accountancy Act (UAA), the system regulating the CPA profession is still fragmented so there is inconsistency in how the competence and quality of CPAs is established and monitored across the 55 jurisdictions (Schaefer & Zimmer, 1995).

THE LICENSING DEBATE

Those who support mandatory licensure argue that licensing serves the public interest by providing a mechanism through which unbiased standards of education, training, and competence are guaranteed thus reducing the detrimental effects of asymmetrical information and assuring quality of services provided by practitioners (Adams et al., 2002; Leland, 1979; Shapiro, 1986; Svorney, 2008).

Asymmetric Information

For many occupations, the general consumer is unable to assess the quality of services provided by a professional, especially in the health care and accountancy professions. Practitioners (sellers) typically have a greater level of information and understanding than consumers (buyers) of the services being

provided (Leland, 1979; Shapiro, 1986). Mandatory licensure, proponents argue, reduces asymmetrical information between the professional (seller) and the consumer (buyer) and thus reduces the transactions costs to consumers created by this lack of information and ability to discern levels of competency and quality (Adams et al, 2002; Leland, 1979).

Licensing and Quality Assurance

The dominant argument in support of mandatory licensing is that it serves to protect the public from incompetent, irresponsible, and untrustworthy practitioners (Kleiner & Krueger, 2009). Licensure serves a vital public interest by assuring that licensed professionals meet minimum standards of knowledge and training established for the occupation; low-price, low-quality practitioners, charlatans and those who would harm the consumer through the delivery of dangerous or sub-standard service are eliminated from the market further protecting the welfare of the consume and improving the quality of services provided by practitioners (Holcombe, 2003; Leland, 1979; Potts, 2009; Shapiro, 1986). Furthermore, licensure provides an incentive for professionals to maintain knowledge and skill levels (Potts, 2009).

While most professional licensure boards require recertification or presentation of evidence of continuing education in their licensed profession, there is no indication that professionals would not voluntarily seek to maintain or upgrade knowledge and skills. Apart from mandatory licensing requirement, desire to maintain one's professional reputation, ability to continue working for a specific organization or to maintain membership in professional organizations would provide a strong incentive to engage in professional development (Potts, 2009; Shapiro, 1986). In addition some licensing boards only require evidence that continuing education credits have been completed and no reassessment of knowledge or skills is required after initial requirements for entry into the professional have been met (Potts, 2009).

The evidence has not supported the contention that licensed compared to unlicensed professionals in non-healthcare occupations consistently provide higher quality services. Among barbers, Timmons and Thornton (2010) noted that stricter licensing requirements did not result in higher quality barbering services. The effects of mandatory licensing on the quality of cosmetology services provided are mixed; however, there is evidence that licensing may actually result in decreased service quality because of an insufficient supply of licensees (Carroll & Gaston, 1981).

Audet and Johnson (1985) examined the impact of credentialing on performance quality of radiological technologists. Audet and Johnson concluded that while minimum standards of knowledge and skill might have increased quality of protection practices there was little evidence beyond credentialing, extensive education and mandatory licensing resulted in improvements in job performance.

Within the CPA profession, while continuing education is required, once initial licensure has been obtained, CPAs are not re-examined to ensure levels of knowledge and skill has been maintained over time. The self-regulated quality review process is effective in assessing and assuring the competency of practitioners and the services provided to the public (Casterella et al., 2009; Morrison & Slough, 2009). Therefore, the on-going review process becomes a more powerful tool for serving the public interest in assuring competence and quality than mandatory licensure.

The most vocal reason cited for mandatory licensure is to protect the public from incompetent healthcare. However, mandatory licensing fails to assure quality of care provided by healthcare practitioners. Typically, state medical boards are given the responsibility for disciplinary actions of physicians. This involves dealing with complaints against medical professionals by the general public (Bovbjerg, Aliaga, & Gittler, 2006).

However, state medical boards have under reported problems and have a poor record of dealing effectively with incompetent or unscrupulous practitioners (Bovbjerg et al., 2006; Leape & Fromson, 2006). Delays in reporting of negligent care and

failure to make disciplinary actions public denies consumers valuable information that would help them avoid obtaining poor quality care (Svorney, 2008).

There is a high rate of repeat offenders among physicians sanctioned by state medical boards, suggesting that licensing does not deal with offenders in an effective way (Grant & Alfred, 2007). Medical professionals often do not report observed impairment or incompetency of colleagues and state medical boards do not have the financial or personnel resources necessary to investigate complaints or to discipline errant physicians (Grant & Alfred, 2007). Overall, Licensure protects unscrupulous or incompetent clinicians more that it protects the consumer (Svorney, 2008).

Further weakening quality assurance is government mandated licensure laws that only require physicians to meet specified standards to gain entry into the profession (Svorney, 2008). Once conferred, physicians hold their licensure for life unless rescinded for gross negligence/incompetence or criminal/disciplinary activities. There are no requirements of reassessment through periodic testing to confirm continued competency.

Physicians are required only to submit documentation of completion of a specified number of continuing education units over a specified period of time (Holcombe, 2003). Lacking are mechanisms for ensuring physicians maintain knowledge and competency levels over time (Grant & Alfred, 2007).

If the purpose of mandatory licensure is public safety then mechanism for periodic re-testing and recurring raining would be implemented to serve as a means of assuring physician knowledge, competency, and skill levels required for initial licensure have not declined over time (Holcombe, 2003; Svorney, 2008). There are no requirements to ensure knowledge and skill levels have not declined over time and physicians benefit from the low requirements to remain licensed (Holcombe, 2003).

Finally, mandatory licensure reduces quality of services provided in the long-term because it acts to stifle innovation due to the general inelastic demand of licensed occupations and

standardized scope of practice requirements (Holcombe, 2003; Potts, 2009; Svorney, 2008). In addition to restriction of competition and reduced motivation to adopt new approaches of models, professionals and others are restricted in their ability to try new business or practice models or to integrate service delivery (Potts, 2009).

Higher Wages and Increased Costs to Consumers

Since the medieval days of the guild trades, members of occupations have sought to control entry of skilled workers as a means of controlling wages (Kleiner & Krueger, 2009). According to the monopoly model of occupational licensing, when a licensing authority governs a large geographical area, the supply of workers is more restricted resulting in the ability to control entry into the occupation and increase wages (Gelhorn, 1976; Kleiner & Krueger, 2009).

Kleiner and Krueger (2009) reported that higher wage gains among occupations requiring federal or state licensure compared to occupations only requiring licensure in local municipalities. While government certification does not lead to wage increases relative to non-certified workers in the same or similar occupations, mandatory licensing is associated with a 15%-18% increase in wages when factors related to education and training are controlled for to account for the differences in education and training of licensed and unlicensed occupations (Kleiner & Krueger, 2009, 2010).

Licensure creates a price wedge by raising minimum prices that limits accessibility because some consumers are priced out of being able to afford the services provided by the professional (Gelhorn, 1976; Potts, 2009). Because mandatory licensure results in increased costs to consumers associated with higher wages, the result is a reduction in overall consumer welfare due to increased costs and lower levels of accessibility (Friedman, 1962; Friedman & Kuznets, 1945; Stigler, 1971).

This lack of accessibility leads many people [often lower-income consumers] to “cut their own hair, arrange their own flowers, design their own interiors, argue their own legal defense and remedy their own teeth because the market for lesser quality but sufficient services has been legally foreclosed” (Potts, 2009, p. 73).

Evidence supports the argument that licensure increases wages for many licensed occupations that require graduate level programs of education and training (Carpenter & Stephenson, 2006; Kleiner & Krueger, 2009; Schaefer & Simmer, 1995; Timmons & Thornton, 2008). More stringent licensure standards for optometrists (Feldman & Begun, 1985), dentists (Kleiner & Kudrle, 2000) and lawyers (Kleiner, 2000; Tenn, 2001) have resulted in increased wages in these and other occupations from 1% to 340% (Timmons & Thornton, 2008).

The evidence is more mixed for occupations with less stringent educational requirements (Timmons, & Thornton, 2008). For example, Kleiner (2000) reported that wages for occupations requiring licensure but that do not require a college degree (e.g., barbers and cosmetologists) were comparable to wages for unlicensed occupations with similar levels of training.

Thornton and Weintraub (1979) and Kleiner (2000) reported no significant effects of mandatory licensing on wages; barbers who were licensed did not have significantly higher earnings compared to non-licensed barbers. However, when controlling for factors such as sex, race, and age, compared to unlicensed barbers, licensed barbers earned between 11% and 22% higher wages (Timmons & Thornton, 2010).

As of 2010, six states provide for the licensure of barber assistants who perform a limited set of barbering tasks (e.g., shampooing or cutting hair but not tasks such as coloring or bleaching) (Timmons & Thornton, 2010). These assistants earned wages 16% higher than in states that do not grant assistant licensure (Timmons & Thornton, 2010). Wages differences between licensed and unlicensed barbers are higher than those

found between licensed and unlicensed workers in similar occupations.

Wage differentials were also noted for cosmetologists and radiologic technicians. Adams et al. (2002) reported that wages for licensed cosmetologists did increase compared to similar non-licensed occupations. Mandatory licensure in cosmetology profession has a detrimental effect on consumer welfare. Mandatory licensing of cosmetologists has been demonstrated to result in price increases as high as 19%, lower quality of services provided, and decreased demand for services brought about by more stringent education and training requirements (Adam et al., 2002; Carroll & Gaston, 1981).

According to Adams et al. (2002), “relatively mild restriction in an otherwise competitive industry may amount to a large redistribution from consumers to the beneficiaries of regulation (cosmetologists) as well as a significant welfare loss to society” (p. 273).

Timmons and Thornton (2008) found wage increases for licensed radiologic technicians. Among radiologic technicians, when controlling for differences resulting from place of employment, specialization, sex of the technician, or strictness of the state licensure regulations, technicians in states that require licensure have wages that are 3.3% to 6.9% higher compared to unlicensed technicians (Timmons & Thornton, 2008).

For each five year increase in the time that a state required licensing, a 1% increase in wages was noted (Timmons & Thornton, 2008). In addition, higher wages were associated with states that had stricter licensing requirements or had licensing boards with a higher percentage of radiologic technicians serving as board members. Timmons and Thornton (2008) concluded that even in states with mandatory licensure, members of the radiologic technician profession may lobby to have stricter standards implemented as a means of increasing overall wages for the profession. Larger boards have greater success getting stricter licensing standards implemented (Timmons & Thornton, 2008).

Barriers to Entry

Licensing leads to monopolized occupations that create barriers to entry into occupations and thus decreases the supply of practitioners (Friedman, 1962). Mandatory licensure serves more the interests of incumbents and from an economic standpoint results in monopoly rents for new entrants because licensing boards (typically composed of occupational incumbents) have the power to modify entrance requirements that pose unspecified fixed costs to new entrants (Shapiro, 1986).

In addition, the fixed costs for entrance into a licensed occupation result in higher costs for services. When entrance requirements into an occupation become more stringent or new requirements are added (often argued to increase the quality of services provided), this increases the economic costs to those who provide similar services in lower quality or lower cost service markets (e.g., a dental technician making dentures rather than the dentist) (Kleiner & Krueger, 2010).

For barbers, states that require both barbering school and an apprenticeship increase entrance barriers to the profession (Guarisco, 2005; Timmons & Thornton, 2010). In addition to training and competence examinations, barber licensing often include barber shop standards (e.g., ensuring a sterile/clean environment, location of bathrooms to the barber chair, flooring, cleaning of window treatments, location to liquor stores and pool rooms, and having a shop in a mobile home).

Some of these requirements are seen as excessive and serve as barriers to entry. For example, not allowing barber shops to be located in mobile homes is seen as a way of decreasing competition from low-cost, itinerant barbers (Friedman, 1962, 2002; Timmons & Thornton, 2010). For radiologic technicians, increased costs associated with the requirement to complete 24 credit hours of continuing education units every two years serves as a barrier to entry to the profession (Timmons & Thornton, 2008).

The lack of reciprocity provisions in many licensed occupations serve as barriers to entry by limiting mobility of

practitioners (Timmons & Thornton, 2010). Reciprocity is available to barbers providing the licensing requirements in the state in which the barber intends to relocate are similar to the state in which the license was granted. However, additional licensing fees and/or a requirement to pass a state licensing exam are often required (Timmons & Thornton, 2010).

Overall, the restrictions and additional requirements barbers must satisfy to move from one state to another makes reciprocity and mobility costly and can reduce interstate mobility by over 50% (Pashigian, 1980; Timmons & Thornton, 2010)

Reciprocity for cosmetologists varies across states. A few states recognize cosmetology licensure from other states and allow licensed cosmetologists to practice without any other restrictions. Most states permit reciprocity but typically require cosmetologists to demonstrate education and training requirements have been met for the state to which they are seeking reciprocity (Adams et al., 2002).

Physicians who want to relocate to another state do not have automatic reciprocity (AMA, 2012). Many states do not have reciprocity agreements with other states or grant automatic reciprocity for physicians moving from one state to the next and physicians often must meet education, training, and examination requirements for the state. Licensing statutes have become more complex in recent decades adding to entry barriers.

Physicians often experience delays due to the time required for background checks of credentials and past practice history and complying with the new states licensing standards (AMA, 2012). It typically takes two or more months to complete the request for reciprocity and can result in significant costs to the physician in fees required to complete licensure process in the new state and loss of income from closing a practice too early in old state (AMA, 2012).

For CPAs, the adoption of the Uniform Accountability Act by the AICPA and NASBA to promote substantial equivalency in state education and training licensure requirements has helped to ease reciprocity barriers (Aghimien & Fred, 2010; Thomas, 2011;

Voynich, 2007). Forty-eight of 55 jurisdictions have adopted some form of cross-mobility allowing CPAs to move to different jurisdictions or to conduct business temporarily out-of-state (Tampone, 2011).

LICENSURE AND THE POLITICAL/LEGISLATIVE PROCESS

With the move toward service oriented professions, members of different occupations established standards of practice. Those groups that desired legal licensure requirements raised money and lobbied their political representatives as well as local, state, and federal legislatures. Over time, these associations such as the AMA and the Associated Master Barbers of America exerted significant influence in the creation of mandatory licensing laws (Kleiner & Krueger, 2010, Wheelan, 1998).

While there is heavy lobbying for increased licensure, licensure deregulation is very rare. Licensed occupational groups with a vested interest in maintaining or establishing mandatory licensure generally are more organized and have greater resources to influence political and legislative actions compared to consumer groups (Carpenter & Ross, 2008). This results in regulatory capture in which professional groups continue to lobby and put intense pressure on politicians until the desired legislation is obtained (Potts, 2009).

For example, physicians pushed for mandatory licensure not because consumers demanded it but because physicians wanted it. From its founding in 1847, the American Medical Association was determined to get states to require licensure (Holcombe, 2003). Through active lobbying, the AMA persuaded states to establish licensing boards and implement state mandatory licensing. However, while states have regulatory oversight, states follow the guidelines established by the National Board of Medical Examiners (Holcombe, 2003).

Interest groups engage in heavy lobbying to shape licensing requirements and scope of practice for their respective professions

(Dower, Christian, & O'Neil, 2007; Svorney, 2008). For example, the AMA opposed efforts to increase the scope of practice for mid-level clinicians. Issues over scope of practice and mandatory licensing are highly charged in healthcare. Many scope-of-practice laws reflect power politics more than issues of clinician competence. Svorney (2008) expressed the view of many licensure opponents stating that:

licensing requirements and scope-of-practice determinations will reflect the political power of various clinician lobbies rather than the patient's interests in affordable quality care. . . .Licensing and scope of practice laws give the medical professions considerable control over whether other professions may compete with them. That frequently slows the spread of affordable care. Consumers are worse off if licensure and scope of practice laws unnecessarily limit access to care. (p. 6)

Efforts to limit scope of practice are most prominent in healthcare. There is considerable political influence on mandatory licensing. "When government issues licenses to medical professionals, it creates a regulatory apparatus that organized clinicians can manipulate to increase their incomes" (Svorney, 2008, p. 4). Physicians have formed coalitions to lobby for retention of mandatory licensing and watch over groups seeking to expand scope of practice for mid-level clinicians as well as restrict scope of practice of mid-level clinicians (Davis, 2007). Several states have created legislative committees to examine scope of practice issues (Svorney, 2008).

The desire to control entry into a profession and scope of practice is not limited to physicians. Mid-level clinicians groups have begun to lobby for licensing restrictions being placed on professionals in their respective occupations similar to the efforts of the American Medical Association and other physician groups to place restrictions on physicians through licensing (Potts, 2009; Svorney 2008).

For example, some nursing organizations have lobbied to have increased educational requirement placed on nurse practitioners that include a minimum of a masters level of education (Svorney, 2008) and the Association of Colleges of Nursing has pushed for a doctoral degree be required for advance practice nursing licensure (Svorney, 2008). In addition, different mid-level clinician groups (e.g., nurses) have lobbied against expanded scope of practice for other mid-level clinician occupations (e.g., physician assistants) (Svorney, 2008).

Current legislative policy makes it difficult to expand scope of practice licensing laws for mid-level clinician occupations. Often those responsible for creating or changing licensing requirements demand that proposed changes be supported by evidence that the change in licensing legislation addresses a verifiable need and provide information about the anticipated effect the change would have on practitioners as well as patient safety (Holcombe, 2003; Svorney, 2008).

Interestingly, evidence of change in scope of practice by the state medical boards only address proposed increases in scope of practice and not how limited scope of practice for mid-level clinicians effect practitioners, patient safety, and accessibility to medical care (Svorney, 2008).

In 2012, the IRS implemented strict licensing requirements those who provide tax preparation services. The new regulations were backed by heavy lobbying from large tax preparations firms such as H & R Block and Jackson Hewitt Loving et al. v. IRS, 3/13/2012, pars. 52-53). Through lobbying, these large firms gained tax exemption while the small or independent non-CPA tax preparers were not. This in effect gave the large firms a significant competitive advantage over the individual or small firm tax preparer who must absorb significant financial and opportunity costs to comply with the new licensing requirements (Loving et al. v. IRS, 3/13/2012, par. 29).

QUALITY ASSURANCE WITHOUT MANDATORY LICENSURE

In place of mandatory licensing, high standards of occupational competence and quality of services provided by professionals can be obtained through alternative mechanisms that raise or maintain quality but lowers costs and increase accessibility to the consumer (Casterella et al., 2009; Holcombe, 2003; Morrison & Slough, 2009; Potts, 2009; Svorney, 2008). Use of brand names and third-party certification that exists to some extent can become an integral part of quality assurance across occupations including healthcare.

Brand Names

Brand names often are associated with assurances about the quality of a product or service within the market place. Companies advertise their goods and services under brand names that build a reputation over time (good and bad). Companies that have built a strong brand name associated with high quality have a strong incentive to maintain customer trust and loyalty without regulatory oversight (Holcombe, 2003).

Products and services with strong brand names can command higher prices in the market such as the world renowned Vidal Sassoon and John Frieda Hair Care salons that provide barbering and cosmetology products and services. While branding is not used much in the healthcare industry, names such as the Mayo Clinic and St. Jude's Children's Hospital have developed brand name status with the American public. These healthcare institutions have acquired reputations for high quality care and accessibility to the public (Holcombe, 2003). Many consumers recognize and trust the tax preparation services provided by H & R Block and Jackson Hewitt. In addition, membership in the AICPA can provide brand name assurance for CPA competence.

The AMA also has acquired a brand name for assuring quality health care through its well-respected publications and accreditation activities. The AMA provides the same quality assurance to consumers provided through mandatory licensing. All

members of the AMA must meet current government education, training, and examination requirements outlined in mandatory licensure laws (Holcombe, 2003).

If mandatory licensing were eliminated, the AMA currently is positioned to assure physician skill and competence to provide quality health care (Holcombe, 2003; Potts, 2009; Svorney, 2008). With a brand name for quality assurance, more physicians would display or advertise their affiliation with the organization (Holcombe, 2003).

Hospitals also can have brand name recognition for assuring quality of care provided by physicians and mid-level health care clinicians (Holcombe, 2003; Svorney; Potts, 2009). Hospitals can play an increased role in assuring physicians and other healthcare providers by monitoring and evaluating provider skills, competency, and ethical behavior. Because hospitals frequently self-insure they bear the cost of malpractice directly; this serves as a strong incentive to maintain a staff that provides high quality care. When insurance is purchased by an outside company, history of poor quality care can lead to higher premium costs so hospitals still have an increased incentive to assure quality (Holcombe, 2003).

In addition, healthcare entities that hire clinicians can be held accountable for negligence and incompetence of licensed professionals. This provides an incentive for those health care organizations to maintain a staff of high quality health care professionals (Holcombe, 2003; Potts, 2009). "Hospitals and other healthcare providers are legally liable for the actions of clinicians whose background and skills they have assessed. When a negligent clinician is employed by a health care organization, the courts may hold the employer liable" (Svorney, 2008).

Insurance companies have brand name recognition (e.g., Aetna, Prudential, Blue Cross). Insurance companies also could provide brand name recognition for the physicians insured. Insurance companies use malpractice insurance premium rates as an incentive for practitioners to keep medical errors low in order to avoid high premiums (Svorney, 2008).

Companies would maintain information on physicians for the general public and only cover the cost of care for providers who have good records of care; a list of these physicians would be advertised by the insurance company. Names like Medical Protective (a Berkshire Hathaway company that insure physicians, dentists, and other healthcare providers), Nurse Service Organization (provides individual malpractice insurance for nurses), CM&F Group Inc., (physician assistants), Cosmetology Insurance Plus or Hands-on-Trade Association (cosmetologist liability insurance), BarberSecure (barbers) could serve as brand name signaling the quality of the care provided by professional to whom the company confers that brand name and image (Holcombe, 2003).

Third-Party Certification

A weakness of governmental mandatory licensure is that it does not encourage practitioners to exceed the minimum standard required for entry into the profession. In many occupations, especially among physicians, there is no ongoing assessment to differentiate levels of quality above those minimum standards (Holcombe, 2003; Svorney, 2008). Licensure removes the incentive for practitioners to improve beyond minimum competence levels and for the consumer to seek after or demand greater information that discriminates between levels of quality of licensed practitioners (Holcombe, 2003; Potts, 2009).

In addition to branding, non-government third-party entities can serve as certifiers of quality. This is accomplished to some extent by publications such as *U.S. News and World Reports* and *Consumer Reports* that rate a wide range of products and services including healthcare institutions and providers (Holcombe, 2003).

A prime example of a successful third-party entity that certifies safety and quality is best exemplified by the standards set and certified by the Underwriters Laboratories (UL) who test and certify the quality and safety of electrical devices (Holcombe, 2003). Electrical equipment meeting UL standards are permitted to carry the UL seal of approval. No manufacturer or seller is

required to obtain the UL seal, but the seal has obtained a strong reputation for safety and quality that most consumers would not purchase products without the seal. Furthermore, the cost for testing and certification is paid by the seller and not the consumer.

Within the CPA profession, the AICPA serves as a third-party entity that certifies the competency of its members. Membership in the AICPA is voluntary but membership is strongly desired because of the reputation the AICPA has for assuring the quality of services provided by its members.

Government mandated licensing regulatory agencies are funded by tax revenues but with third-party certification, the cost would be shifted from the consumer to the seller. Occupational practitioners would voluntarily submit to pay for third-party certification. Even when not required by law, practitioners would seek this certification or forgo the higher wages and higher demand for services that accompany certification by a trusted third-party. The loss of consumer trust, loyalty and revenues would serve as an incentive for third-party certifiers to certify only those practitioners who meet competence and quality standards set by their occupation.

Insurance companies can play a significant role as third-party certifiers of quality of practitioners in both healthcare and non-healthcare occupations. Malpractice premium rates and discounts can serve as strong incentives for both non-healthcare and healthcare providers to maintain a high quality of care (Svorney, 2008). For example, insurance companies could pay for providers who are certified to meet the standards set by their respective occupations.

Within the healthcare industry, some insurance companies offer discounts for practitioners who complete programs designed to reduce medical errors and increase the quality of care (Svorney, 2008). Higher premiums, restricted or denied coverage for non-healthcare and healthcare service providers would be based on a variety of factors such as membership in occupational governing or certification associations, failed examinations, lack of certification

and high malpractice claim rates also induce improvements in quality of services provided (Holcombe, 2003; Svorney, 2008).

In terms of the healthcare industry, third-party certification is already a part of the quality assurance. The primary responsibilities of state licensing boards include checking the credentials of clinicians, taking disciplinary action against licensed practitioners, establishing education and training requirements, and administering examinations and setting pass rates (Bovbjerg et al., 2006).

Interestingly, state medical boards often rely on private third-party entities that do a significant amount of work such as administering a national test, assessing physician training, and accrediting medical schools (Svorney, 2008). This is also true of the CPA profession in which the state boards of accountancy follow the recommendations from the AICPA and NASBA. If licensing laws were eliminated, these private entities would fill the need for providing information about practitioner qualifications and competency.

Though certification is not required by law, many physicians seek board certification in their medical specialties. Typically board certification is more rigorous than state licensure requirements (Svorney, 2008). In the United States, 85% of physicians have obtained some form of board certification (Svorney, 2008).

Since 2010, all specialty boards that are members of the American Board of Medical Specialties have adopted a set of “maintenance of Certification” standards. Unlike mandatory licensing, physicians who desire board certification must undergo periodic re-evaluations to maintain the specialty certification (Cassel & Holmboe, 2006). Board specialty certification has become a widely used indicator of quality; hospitals and other healthcare organizations predominantly hire board certified clinicians (Svorney, 2008).

The National Committee for Quality Assurance requires managed care preferred providers and other healthcare organizations to credential clinicians working for their

organizations (Holcombe, 2003; Svorney, 2008). An industry of credentialing verification organizations has emerged that collects and provides information about training, experience, malpractice claims, and judgments against healthcare providers (Svorney, 2008). The Federation of State Medical Boards' Credentials Verification Services created in 1996 provides records both for physicians and physicians assistants (Svorney, 2008).

Applicants establish a record of core credentialing and a lifetime portfolio of professional services that can be forwarded to any entity at a physician's request (AMA, 2012; Svorney, 2008). The National Commission on Certification of Physician Assistants, the Accreditation Review Commission of Education for the Physician Assistant, the American Nurses Credentialing Center, and the American Academy of Nurse Practitioners are just a few of the non-governmental certifying organizations assuring quality care by mid-level clinicians (Svorney, 2008).

CONCLUSION

Over time, the number of occupations requiring licensure has increased under the guise that mandatory licensing serves the public good. Mandatory licensing continues to expand across occupations resulting in the redistribution of rents from the non-licensed to the licensed as well as stifling innovation and inhibiting professionals from trying new business models (Potts, 2009).

The quality and safety of services can be difficult for the consumer to observe directly. The general public often relies on a third-party able to assess and certify the quality of services demanded by the consumer. Government mandatory licensure is purported to provide this service. However, private entities and market processes could produce the same results at less cost to the consumer (Holcombe, 2003).

Among the non-healthcare occupations that include barber, cosmetologists, and CPAs, mandatory licensure has detrimental effects on both practitioners and consumers. For barbers, stricter mandatory licensing result in fewer practicing barbers, higher entry costs, and a decreased supply of barbers that would be found with

less stringent licensing restrictions. In addition, states with stricter licensing result in higher wages for barbers and higher costs for barber services (Timmons & Thornton, 2010).

Among cosmetologists, mandatory licensure increases barriers to entry, decreased supply of practitioners and increased costs to the consumer related to higher wages for licensed compared to non-licensed cosmetologists (Adams et al., 2002). For CPAs, licensure increases financial and opportunity costs that can pose significant barriers to entry especially for the economically disadvantaged and those from minority groups (Carroll, 2005; Schaefer & Zimmer, 1995; Van Wyhe, 2007). This results decreased supply of practitioners, higher wages for CPAs, increased fees and reduced choice for consumers (Aghimien & Fred, 2010; Carroll, 2005).

In terms of healthcare, Friedman (1962), Kessel (1958, 1970), and Arrow (1963) were early advocates for the elimination of mandatory licensing. These economists noted that mandatory licensure was restrictive and raised the cost of care by requiring physicians to perform tasks that could be performed effectively by less-skilled mid-level clinicians at less costs (Arrow, 1963; Svorney, 2008). Allowing non-physicians to do more tasks they are qualified to perform would result in increased accessibility to health care at lower costs.

Mandatory licensing for healthcare providers does not serve the public interest because it results in increased barriers to entry in to the profession, increased health care costs, and decreases accessibility to health care especially for the poor (Svorney, 2008). In addition, most licensing laws do not adequately protect the consumer (Holcombe, 2003; Potts, 2009; Svorney, 2008). Health care providers such as hospitals, clinics, and Health Maintenance Organizations often have more complete and current information about the competence of the clinicians employed and the quality of care provided (Svorney, 2008).

If mandatory licensure were eliminated, private entities could provide credentialing of non-healthcare professionals (e.g., barbers, cosmetologists, CPAs), physicians and other health care

providers. Hospitals, managed care organizations, and other health care provider entities provide quality assurance through their screening of new hires, limitations on scope of practice based on skills, training, and record of providing quality care, and procedures in place to evaluate each clinician hired and to determine scope of practice privileges consistent with job responsibilities (Holcombe, 2003; Svorney, 2008).

Associations such as the NASBA and AICPA provide quality assurance through the peer review process, negating the need for mandatory licensure (Castereaal et al., 2009; Gramling & Watson, 2009; McCrone, 2010; Morrison & Shough, 2009).

Alternatives that serve as effective indicators of competence and quality of services provided by professionals exist through private-sector certification, institutional oversight, and litigation to provide consumer protection. Certification, credentialing, and scope of practice decisions can be effectively administered by private sector entities and the courts (Aghimien & Fred, 2010; Casterella et al., 2009; Morrison & Shough, 2009; Svorney, 2008).

Board certification, hospital privileges, membership in local, regional, and national medical associations, and affiliation with insurance groups (HMO, PPO) provide valuable information to the public for healthcare provider competence. AICPA membership indicates to the consumer that CPAs have met quality standards for competency in the services provided. Local, state, and national reviewers of barbers and cosmetologists similar to Zagat's review of restaurants can provide the consumer with information about the quality of barbering and cosmetology services. The general public currently has several third-party information sources that help in the decision-making process with more watchdog groups forming every year.

Overall, the market is better able to ensure quality of products or services than can be provided by a governmental regulatory entity. In any profession, when the seller is not inclined to provide high quality services, there is often an incentive to hide prior poor quality. Without mandatory licensing, private sector

regulatory agencies would take on the responsibility of assessing competence and the quality of difficult to observe provider services.

A third-party can provide verification that a seller produces a level of quality desired by the buyer. Third-party entities can gather information and provide for free or sell information ratings of the quality of the goods and services provide by professionals. Market demand for such information would result in periodicals and other information outlets being created devoted to providing this information to the public. In this sense, third-party institutions would substitute for prior government regulation (Holcombe, 2003).

Because the government has in place a regulatory system financed through tax dollars, there is little incentive to establish private sector regulatory agencies (Holcombe, 2003). Eliminating governmental mandatory licensing would shift the cost for regulating from the consumer who pays for governmental licensing oversight through tax dollars, to private sector entities and practitioners (Holcombe, 2003). Private sector regulation would be more efficient than government regulatory oversight.

Because practitioners (sellers) would pay for private sector certification and buyers (consumers) would rely on the agency information provided, the private sector agency compared to a governmental regulatory agency has a greater incentive to provide a high quality regulatory service for lower costs. The private sector agency would have to demonstrate that their regulatory performance justify the cost to practitioners and consumers who use the agency's services. In addition, it would be easier for private sector agencies to deny a practitioner certification than a governmental regulatory agency (Holcombe, 2003; Svorney, 2008; Young, 1987). Finally, private sector regulatory agencies would be more responsive to changes needed than governmental agencies which have a record of being slow to respond to need for change (Holcombe, 2003).

According to Friedman (2002), it is not likely that licensure requirements will be phased out any time soon because those who

advocate for licensing have a greater vested interest and expend more time and resources in lobbying activities compared to consumers. However, in the current market economy, as increased substitutes (e.g., cosmetologist, hairstylists, and unisex salons as a substitute for barbers and nurse practitioners and physician assistants as a substitute for physician care) become more prevalent and consumers choose substitutes more frequently, price and wage earnings will become more elastic thus weakening the earnings and power of the licensed professions (Moncarz & Reaser, 2002; Timmons & Thornton, 2010). Non-governmental entities co-exist with current governmental mandatory licensing laws. If non-governmental mechanisms for assuring quality were allowed to work unimpeded by the government, quality would improve over time serving the best interest of the general public at lower cost and with increased accessibility in the long-run.

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