



**Australian Society of Otolaryngology Head and Neck
Surgery – ASOHNS**

Submission

to the

Senate Community Affairs Committee

Inquiry into the

National Registration and Accreditation Scheme

for doctors

and other health workers

April 2009

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Executive summary

The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) is the representative organisation for Ear Nose and Throat Head and Neck Surgeons in Australia and dates from 1950. ASOHNS members are Specialist Surgeons who investigate and treat conditions of the ear, nose, throat and neck.

ASOHNS has serious concerns with the proposed National Registration and Accreditation Scheme (the scheme) put forward by the Council of Australian Governments (COAG). ASOHNS welcomes the Senate Community Affairs Committee inquiry into the scheme as the significance of this proposal cannot be underestimated. The scheme will determine and devalue the quality of Australia's healthcare workforce for all time. It is appropriate that the scheme be thoroughly examined and scrutinised, including by the Federal Parliament, for its potential impact on the high standards of healthcare that Australians have come to expect and currently experience.

ASOHNS acknowledges that, amongst the hundreds of millions of medical services provided in Australia each year, there are isolated cases where patient safety and quality of care have been unacceptably compromised. The medical profession and the Australian community must do all that it can to protect individuals from doctors acting beyond their capacity, or who cause harm to their patients. But we know that in reality there is no single system that will absolutely prevent isolated cases of harm in the healthcare system.

Patient safety and quality of care is dependent on a system that ensures standards for health profession education and training, registration and practice are developed and maintained at the highest level. The medical profession understands this and therefore demands excellence of itself and all those who join it.

ASOHNS is strongly of the view that the highest standard of patient safety and quality of care can only be achieved through an autonomous process for developing and setting accreditation standards, by a body that involves the highest level of professional expertise and input, free from political and bureaucratic interference.

The proposed COAG scheme passes absolute control of Australian medical standards to governments and bureaucrats. If the scheme is introduced, it will give politicians ultimate authority over accreditation standards for medical education and training courses, and professional standards for medical practice. There will be no autonomy of the process for setting standards and the medical profession will lose its ability to maintain the highest professional standards.

COAG claims the scheme will provide a system of national registration which would improve patient protection and safety. ASOHNS believes that in fact the proposed scheme for National Registration and Accreditation that is being progressed will lower the standards expected of the medical profession and jeopardise patient safety and quality of care.

The AMA alternative model to the proposed scheme retains the autonomy of the accreditation process thus protecting patients by only accepting high quality doctors while at the same time providing a system for a national registration arrangement which will deliver consistency of standards for the medical profession across Australia. ASOHNS supports this model.

ASOHNS wants to ensure that only suitably trained and qualified medical practitioners are able to practise, and that a national registration system will allow those doctors to work in more than one jurisdiction i.e. across State and Territory boundaries.

The scheme extends its powers to do much more than facilitating the mechanism by which medical practitioners are able to practise across the country without having to re-register in another jurisdiction.

In bringing the registration and accreditation functions together under the administration of a government agency, and combined with ministerial approval of all health profession standards, the scheme gives absolute control of health profession standards to Health Ministers and bureaucrats. The scheme is flawed because it permits political interference in the setting of standards, and hence destroys the international recognition of the national accreditation system that is currently in place for the medical profession in Australia.

It removes the autonomy of the functions of the expert body that sets the standards for the medical profession. Consequently, the architecture of the scheme provides a framework for the lowering of medical standards. At the same time the scheme provides a framework for lowering expected standards for the delivery of healthcare by expanding the roles and scopes of practice of other health professions outside the training, skill set and expertise which is necessary to maintain high quality health outcomes for Australians.

ASOHNS believes that Health Ministers will be able to put workforce supply and budget imperatives above high medical standards in order to:

1. fast track medical practitioners with lower skill and experience into the workforce;
2. permit underqualified medical practitioners to work inappropriately outside their scope of training and practice; or
3. allow non-medically trained health professionals to act in a capacity beyond their education and training.

Accordingly, the scheme could introduce, not mitigate, risks to patient safety and quality care in the Australian healthcare system.

The broader health workforce reform agenda that is being pursued by health ministers and state and territory governments, in the context of the introduction of the scheme, should be explained to the Australian public.

Once the bar is lowered on health profession standards it will be almost impossible to raise in the future. The experiment is likely to prove detrimental to the health care of Australians.

Further, there are no design features that show the scheme will be equal to or better than existing arrangements in protecting the public from isolated cases. In fact ASOHNS believes that the new scheme is more likely fail to protect the Australian people. It has a workforce agenda as a priority above quality and safety (as has been described). It is bureaucratic and less responsive to State needs. It is more remote from the complaints investigation processes and therefore less responsive to the needs of the people.

ASOHNS is also concerned that the scheme threatens the international standing of Australian trained doctors. Under the scheme, accreditation of medical education and training may not meet international guidelines. Australian medical training may no longer be recognised internationally, with consequences for Australian doctors and overseas medical students who train in Australia.

Finally, ASOHNS contends the scheme will be cumbersome and expensive.

ASOHNS firmly believes that we can achieve a national system of medical practitioner registration with a simple, cost effective, alternative that:

1. maintains the nationally consistent accreditation of medical education and training through an independent medical accreditation body with specific medical expertise;
2. implements mutual recognition of registration arrangements for medical practitioners across all states and create a 'virtual' national register; and
3. establishes a formal process for ongoing harmonisation of registration standards.

This submission:

- explains and comments on the existing arrangements for the setting of medical standards;
- outlines our understanding of the COAG proposed framework;
- provides an acceptable alternative to the COAG proposed scheme; and
- variously addresses each of the terms of reference for the Committee inquiry in the discussion.

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Existing arrangements

Doctors make a unique commitment to society when they join the medical profession - to serve the needs of patients above all else through a longstanding tradition of medical ethics and professionalism. This embodies the profession's social and moral relationship with society where the profession uses its highly specialised knowledge and skills to serve the health needs of patients and the wider public. Through an adherence to an open and accountable system of self-regulation, doctors use their unique expertise to set and reinforce the highest ethical and professional standards of practice, competency, and conduct to improve the safety and quality of the health care system. Self-regulation incorporates setting and reinforcing ethical codes as well as standards for education and training, including continuing professional development, and conducting appropriate review and discipline of conduct matters.

Consequently, Australia has a high standard of medical education and training and the requirements for registration as a medical practitioner are also high.

Beyond the expectations of the profession itself and self regulation, the governance and accountability for medical professional standards in Australia currently occurs through three separate processes:

1. Registration of medical practitioners by medical boards under state and territory laws, with complaints and disciplinary processes;
2. Accreditation of medical education and training programs by the independent national standards body, the Australian Medical Council (AMC); and
3. Setting of medical practice standards (or competencies) for specialist qualifications by national specialist medical colleges.

While none of these processes have direct influence over the other, they are complementary. Broadly under these arrangements, registration of Australian trained doctors is based on completion of education and training courses that are provided by universities and specialist medical colleges and which have been accredited by the AMC. The AMC sets the standards that must be met in the required training delivered by medical schools for the primary qualification in medicine (Bachelor of Medicine, Bachelor of Surgery) and the training provided by the medical colleges to achieve specialist qualifications. The AMC and the medical colleges also play a significant role in assessing the qualifications of overseas trained doctors.

Registration standards for the medical profession have evolved over time in response to local issues. Similarly, accreditation and medical practice standards have evolved in response to advances in medicine and medical practice. Changes to medical standards are almost always implemented through a cooperative approach involving the medical boards, AMC, medical colleges, health departments and relevant stakeholders with a high level of input from the medical profession to ensure standards are maintained.

Currently, at a functional level, state and territory health ministers variously have input into medical and educational standards for registration purposes within their own jurisdictions. This allows individual ministers to take account of and respond to local issues at the jurisdictional level. For example, jurisdictions can classify 'areas

of need' which permits doctors (e.g. international medical graduates) who do not meet the requirements for full registration to be registered to practice in these areas, but with appropriate limitations on their scope of practice. Medical boards require these registrants to make reasonable progress towards full registration. These registrants may have formal conditions defined in their registration status, for example they must be supervised.

At a practical level, individual jurisdictional health ministers are limited in their ability to influence the AMC national standards for accreditation of medical education and training, or the medical colleges in respect of medical practice standards. This is entirely appropriate. It ensures consistency of medical education and training across the country - medical students graduating from Queensland universities will be as well trained as medical students graduating from universities in Western Australia.

One final layer of protection for the public exists within the credentialing arrangements for doctors to be employed in specific positions in healthcare organisations. These arrangements involve peer review and ensure that, within a healthcare organisation, care is provided by qualified professionals whose performance is maintained at an acceptable level. This delivers an appropriate match of the individual doctor's skills to the specific health facility where they are working.

Accreditation of medical education and training

Accreditation of medical education in Australia has achieved a high degree recognition and buy-in by the relevant stakeholders. The ability of the AMC to set standards and to administer the accreditation processes, free from direct government influence, is an important factor in ensuring it remains compliant with international guidelines. These guidelines¹ require that the legal framework for a country's system of accreditation of basic medical education should:

- secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession; and
- authorise the accrediting body to set standards.

The practical effect of compliance with these international guidelines is that Australian qualified doctors can have their training recognised if they want to work overseas. Many Australian trained doctors will seek work overseas as part of their speciality training, for additional skills and experience, very often with the intention of bringing these back to treat patients in Australia. Equally, international students are willing to pay to be trained in Australia because their qualifications will be recognised when they return home. International full fee paying medical students contribute to our universities and the economy. Loss of international recognition of accreditation processes would adversely impact on both these aspects.

The medical profession has confidence that expert professional input into the processes of accreditation and standard setting, without external influences such as

¹ World Health Organisation/World Federation for Medical Education *Guidelines for Accreditation of Basic Medical Education* (Geneva/Copenhagen 2005)

funding and workforce pressures, ensures medical standards are clinically appropriate and maintained at a high level.

Notwithstanding the need for the AMC arrangements to remain independent, it is important to highlight the fact that the existing AMC council and standing committee arrangements are highly accountable and transparent, including through the following processes:

- The Commonwealth and the jurisdictions (under the auspices of the Australian Health Ministers Advisory Council) are represented on the Council and its major Standing Committee (currently by a representative of the Commonwealth Chief Medical Officer and the Chair of the Health Workforce Principal Committee).
- Health Consumers are also represented on the Council, its standing committees and Accreditation Assessment Teams.
- Medical Boards are represented on the Council, standing committees and (periodically) on Accreditation Assessment Teams.
- Medical students and trainees are members of Accreditation Standing Committees and Accreditation Assessment Teams.
- Medical Schools and Specialist Accreditation Reports are made public and are available through the AMC website.
- Recognition of Medical Specialties Reports are made available to the Commonwealth Minister of Health and are also made public when the Minister has decided on the outcome.
- There are comprehensive appeals mechanisms for all of the AMC assessment activities.
- All assessment criteria and examination specifications, including statistics on pass rates, are published on the AMC website and are available in hard copy from the AMC.
- The AMC has produced comprehensive reference publications that detail the content and assessment criteria for all AMC examinations together with detailed commentaries on clinical best practice in the Australia context.

A number of the AMCs processes are subject to external validation and/or compliance with international standards, such as the approval of the medical school accreditation process by the US Federal Department of Education and compliance with WFME guidelines.

The medical colleges role in medical standards

Currently, Australian medical colleges:

- determine specialist qualifications for, and confer them on, medical practitioners;
- provide specialist training programs;
- determine continuing professional development for the medical profession;
- and
- assess overseas medical graduates who are applying for Australian specialist qualifications.

The medical colleges voluntarily submit their training programs for accreditation by the AMC.

Assessment of international medical graduates

In February 2006 the Council of Australian Government agreed to introduce nationally consistent assessment processes for international medical graduates. A great deal of progress has been made towards this objective, with the development of more robust and transparent assessment processes. Where possible, more streamlined assessment arrangements have been agreed.

Many of these changes have been implemented through a cooperative approach involving the AMC, medical colleges, medical boards, the medical profession, health departments and relevant stakeholders. While the final stages of these reforms are still in the process of being introduced, the reforms to date have significantly improved the arrangements for permitting international medical graduates to practise in Australia. In recognition of the higher risks to patient safety and the differing standards of overseas medical qualifications, the new arrangements have been tailored to the very specific circumstances of the medical profession. They have taken over three years to develop and implement. These arrangements should be given time to be bedded down and properly evaluated.

The proposed COAG scheme

In order to illustrate ASOHNS concerns about the proposed COAG scheme, it is necessary to first set out our understanding of what is being proposed. The following information is based on the Intergovernmental Agreement signed by governments on 26 March 2008 (the IGA), the Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 (Qld) (the Act), and the seven consultation papers released by the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee from August 2008 to January 2009. Where necessary, references to relevant information in these documents is footnoted.

Structurally, the national registration and accreditation scheme will consist of:

- the Ministerial Council, advised by the new Advisory Council;
- the new Australian Health Practitioner Regulation Agency (the National Agency) to administer the scheme. The new Agency Management Committee will manage the National Agency; and
- a new National Board for each of the health professions covered by the scheme, to undertake registration and accreditation functions, with assistance from committees established by boards to assist them with their functions.

The Ministerial Council, comprising Health Ministers:

- will provide policy direction to the National Agency and the National Boards²;
- approve health profession standards covering: registration; practice; competency; accreditation; and continuing professional development³;
- while required to approve a health profession standard only if the standard is recommended by the relevant National Board⁴, can request a National Board to review an approved standard or a standard submitted to it by the board for approval⁵;
- will determine modifications to registration categories and practice restrictions⁶;
- approve new specialties of practice on registers⁷ and issue guidance to boards in relation to the criteria for the recognition of specialties under the scheme⁸.

A copy of any direction given by the Ministerial Council to the National Agency or to a National Board is to be published on the website of the National Agency and in the annual report of the National Agency⁹.

² Item 1.25(b) in Attachment A to the Intergovernmental Agreement and Section 7 of the Act

³ Section 8 of the Act

⁴ Subsection 8 (3) of the Act

⁵ Subsection 8 (4) of the Act

⁶ Item 1.29 in Attachment A to the IGA

⁷ Item 1.31(d) in Attachment A to the IGA

⁸ Consultation paper on proposed arrangements for specialists, paragraph b, page 2 (21 January 2009)

⁹ Subsection 12(3) of the Act

The National Agency will administer the scheme in accordance with policy directions of the Ministerial Council. The National Agency will also develop procedures and rules for the operation of the registration and accreditation functions and the operation of the boards and committees¹⁰ and set frameworks and requirements for the development of registration, accreditation and practice standards¹¹.

A National Board will have registration and accreditation functions with respect to the health profession for which it is established. The National Boards will be able to establish committees to assist in the exercise of their functions.

¹⁰ Item 1.17(g) of Attachment A to the IGA

¹¹ Item 1.17(h) of Attachment A of the IGA and paragraph 20(1)(a) of the Act

ASOHNS concerns with the scheme

ASOHNS is primarily concerned that the scheme will dismantle the long-standing arrangements for, and the removal of the autonomy of, the accreditation of medical education and training by the AMC. We are also concerned about the absence of any certainty about the role of the medical colleges in setting and maintaining medical specialist standards.

There is no reason to dismantle these arrangements and replace them with complex political and bureaucratic governance arrangements. Existing arrangements should have been incorporated into the scheme for the medical profession, and could have served as a model for the other health professions.

Consequently, ASOHNS is very concerned that there is no guarantee of a continued role for the AMC beyond the first three years of the operation of the scheme. Further, there is no recognition, let alone guarantee, of a continued role for the medical colleges. At the same time, we are concerned about the new national high level role of Health Ministers in approving standards for and issuing policy direction on registration, accreditation, practice, competency and continuing professional development. ASOHNS sees this as the biggest threat to the high standing of the Australian medical profession, in Australia and internationally.

There is no evidence to demonstrate the scheme will be equal to or better than the current arrangements in achieving the scheme's objectives. In fact, if the scheme is introduced, the nation is about to embark on a bold experiment without any means of measuring the outcomes. The consequences will not be immediately apparent. It will take some time before we understand the extent to which the bar has been lowered on healthcare standards. By then, for some patients, it may be too late.

Lowering the quality of the Australian health workforce

(Terms of Reference B)

The scheme will enable political determination of the quality of Australia's medical workforce, rather than the definition of standards and accreditation of medical education and training being based on the real requirements to achieve an appropriately trained and skilled medical practitioner for registration.

ASOHNS cannot support a scheme that gives politicians ultimate authority over every aspect of medical standards. We believe there is a very high risk that the quality of the Australian health workforce will be diminished, and patient safety and quality of care compromised as a result of decisions taken by Health Ministers for political expediency. Medical practitioners may no longer be as well trained and experienced, and other health professions could be permitted to provide healthcare beyond their scope of training and practice.

ASOHNS believes this is a reasonable assumption because the scheme will be administered under the principle that "the practice of a profession will only be

restricted where the benefits of the restriction outweigh the costs”¹². This suggests that restrictions to ensure the appropriateness of the provider, and the safety and quality of the service provided to the patient, are secondary to “costs”.

Lowering standards at a systemic level

Through its policy directions to, and requests of the National Medical Board to review standards, the Ministerial Council could systematically erode and manipulate medical standards. For example, a policy direction on accreditation standards, and a corresponding policy direction on registration standards, could see shortened training courses being accredited in future as a means of introducing a rapid process for bringing people into the health workforce. Alternatively, policy directions on scopes of practice could see unsafe expansion of other health professions’ roles.

These changes to the health workforce might fast track people into the workforce before they are appropriately qualified compared to today’s standards, and reduce health expenditure by allowing governments to pay less for lower quality services provided by lesser trained health professions. If “costs” are put before patient safety, the overall quality of the Australian health workforce will be reduced, with inherent risk for patient safety and quality care.

Lowering standards at the individual level

The scheme includes provision for the medical board to register a person who does not meet the requirements and standards met by other registrants for general registration in one of two categories¹³:

- Area of need; and
- Temporary registration in the public interest.

The first category already exists in jurisdictional arrangements, but usually with limitations, such as the scope of practice, supervision and review and for specific periods of time. The second category is new.

The fact that neither proposed category contains any requirement that people registered under these categories be supervised, or that such registration be time limited, is evidence that government does not have patients’ interests at heart. This is an issue of great concern to the public and the medical profession and puts at risk the safety and quality of patient care.

We have already seen the results of allowing underqualified medical practitioners to practise independently. The two highest profile cases of doctors causing harm to patients¹⁴ occurred in the public sector in public hospitals where bureaucrats, faced with difficulty attracting medical practitioners for particular positions, departed from agreed processes.

¹² Subclause 5.4(c) of the Intergovernmental Agreement (26 March 2008).

¹³ Consultation paper on proposed registration arrangements – Table 2 page 15 (19 September 2008) and Further consultation Paper on proposed arrangements for specialists – Appendix 1 page 10 (21 January 2009)

¹⁴ the case of Dr Reeves in NSW, as reported in the findings of the Medical Tribunal of NSW, 23 July 2004; the case of Dr Patel in QLD as reported in the Report of the Queensland Public Hospitals Commission of Inquiry, 2005.

It is entirely inappropriate to address short-term workforce supply problems by registering people who do not meet the registration requirements. The recent cases have demonstrated the serious consequences for patient safety and quality care when a “near enough is good enough” approach is taken to filling medical positions in public hospitals.

It is contradictory for a contemporary scheme, with the objective of protecting the public, to *facilitate*, and not prevent, the registration of underqualified medical practitioners. This applies equally to the other health professions.

State and territory governments are already seeking to address short-term workforce supply problems, and perhaps even budgetary constraints, by introducing new categories of health professionals, such as physician assistants, or allowing other health professions to practice independently, e.g. nurse practitioners. Governments are also endorsing courses for other health professions that the profession itself considers are substandard¹⁵. This scheme will allow these decisions to be made more easily and without contemporaneous public or parliamentary scrutiny.

Addressing health workforce supply

The solution to addressing health workforce supply is not to lower the standards of care to be delivered.

The AMA has consistently maintained that the only solution to health workforce supply problems is to train more health professions, and for all health professionals to provide care and treatment within the bounds of their scopes of practice, education and training and skills. ASOHNS supports this belief.

A scheme that facilitates:

1. the systematic lowering of the quality of the health workforce;
2. underqualified registrants to be registered, under any circumstances; and
3. health professions to act in a capacity beyond their scope of training and experience

is not the solution to health workforce supply problems.

The lowering of medical standards and competencies for workforce reasons or cost saving must not be supported. Australia can afford to maintain its highly trained and highly skilled medical workforce. The current workforce shortages have arisen because of a lack of proper planning and poor policy decisions of the past – not because of the length or scope of medical education and training courses.

Autonomous accreditation of medical education and training

(Terms of reference C)

A nationally consistent structure for maintaining the high standards of education and training for the medical profession already exists under the auspices of the AMC.

¹⁵ Australian Nursing Federation press release on approval of Holmesglen TAFE Bachelor of Nursing degree. 7 April 2009

As previously stated, the role of the AMC is consistent with international guidelines for accreditation of medical education. These guidelines are very explicit on this topic, requiring that the accreditation of medical education (including the component of medical education that takes place during clinical training placements) should ensure that quality assessment is independent of government, the medical schools and the profession. Further, the guidelines clearly state that the legal framework must authorise the accrediting body (in this case the AMC) to set standards in respect of medical education and training.

Loss of international recognition of Australian education and training

ASOHNS believes that dismantling these arrangements, and introducing new arrangements through the scheme, would undermine Australia's hard won reputation for excellence in medical workforce training and risk international recognition of students who undertake medical education and training in Australia.

Our own Australian trained doctors will lose international recognition of their primary degrees or specialist qualifications. Currently these are highly respected and recognised, and allow Australian trained doctors to work overseas to increase their experience, further training and expand their skill set, often returning with this added knowledge and experience to work in Australia to the benefit of our health system.

An additional consequence is that with the loss of international recognition under the scheme, Australia will not be attractive to international students as a place to study. Fee paying overseas students make important contributions to universities and to the economy.

The ongoing role of the AMC

We note that a continued and important role for the AMC, beyond the first three years of the operation of the scheme, has not been acknowledged in any of the consultation papers released by government.

Further, any governance model that compromises the effective and independent role of the AMC will not be supported by the medical profession on the basis that quality of patient care could be compromised. We have already outlined the potential for the Ministerial Council to influence medical standards across the spectrum of education and training, registration and medical practice.

The role of accrediting medical education and training, at university, prevocational and college level, must be fully delegated to a body with medical professional expertise and the support and confidence of the profession, such as the AMC.

The accreditation body must remain independent from any outside influence, including from influence or interference in its decisions by all levels of government or any government established body.

ASOHNS accepts that the current arrangements, which allow individual jurisdictions to have some input into the work of the AMC, are appropriate in helping ensure that local workforce issues are drawn to the attention of the AMC. However, ASOHNS

maintains it would not be appropriate for Health Ministers to seek to unilaterally influence the national standards set by the independent accrediting body for medical education and training across the country.

In respect of the medical profession, we can see no justification for the Ministerial Council to have absolute control over accreditation standards. Our view about the appropriate roles and relationships between Ministers, boards and the accrediting body is outlined in further detail in our proposed alternative model.

The role of the medical colleges

Within the scheme, there is no recognition, and no guarantee, of the ongoing role of the medical colleges in training, conferring specialist qualifications, continuing professional development and in the assessment of overseas medical graduates with specialist qualifications.

Specialist endorsement should be on the basis of specialist qualifications conferred by Australian medical colleges, under Australian Medical Council (AMC) accredited training processes. This would include medical practitioners who are on the pathway to an Australian medical college fellowship, as well as college and AMC/college processes for recognising overseas specialist qualifications. This ensures there is consistency in the quality of care provided by doctors and the standards for doctors.

There must be certainty that independent medical practice is undertaken only by practitioners who have specialist qualifications which are accredited by the AMC or whose training and experience have been assessed under the AMC process as substantially comparable to that of an Australian specialist.

In the case where supervision is required for a practitioner they will work under 'oversight' in an AMC defined and accredited position for the time period required prior to applying for fellowship of the relevant medical college.

Professional standards and competencies

Government officials advise us that the primary legislation for the scheme will no longer contain important provisions related to medical registration. Instead, these details will be contained in subordinate legislation in the form of delegated instruments, or guidelines, so that they may be changed easily. This introduces considerable risk that the registration requirements and professional standards and competencies could be inappropriately changed at any time and without public and professional scrutiny and debate.

It also means that certain existing requirements that the medical profession has fought hard to have included in registration may not be carried over to the scheme or may be changed in the future without agreement with the profession. For example, there are specific medical registration requirements for prevocational doctors, such as core terms for interns. These core terms place a compulsion on state governments in respect of clinical training placement in public hospitals. These could be compromised in the future if Ministers want to reduce the clinical training resources that are currently required in public hospitals, as they will have the power to easily change these requirements.

Continuing professional development

Government is being opportunistic in using the introduction of the scheme to also establish new requirements for registrants to demonstrate continuing competence¹⁶.

The medical profession and the medical colleges have a long history of demonstrating the importance of continuing competence through programs for their members (fellows). The medical colleges regularly collaborate on improvements to continuing professional development (CPD) programs, particularly on the cross-profession elements such as professional qualities, behavioural and ethical expectations. Individual colleges determine the particular continuing competency requirements for their respective specialities.

It is unnecessary to replace the medical college CPD programs with a new scheme. College CPD programs should the responsibility themselves.

Absolute control by Ministerial Council

The Ministerial Council will have absolute control over medical standards by virtue of:

- its authority to approve, and request review of, registration, accreditation, practice and competency standards;
- its authority to issue policy direction to the medical board;
- the absence of any provision within the scheme for the medical profession to appeal the decisions of the Ministerial Council to approve standards or issue policy directions to the board;
- the absence of any parliamentary scrutiny of the decisions of the Ministerial Council.

The Productivity Commission held that there should be separate governance arrangements for registration and accreditation of professions because “*it would be good regulatory practice to separate the setting and verification of standards at the education and training institutional level from the application and maintenance of standards in relation to individual practitioners*”¹⁷.

Further, the Uhrig Review (2004) considered the corporate governance of statutory authorities and found that “boards should only be used when they can be given full power to act” and that it is not feasible to have a board in situations where Ministers play a key role in the determination of the policy.

Neither of these principles are reflected in the scheme’s architecture.

The medical profession cannot support a scheme if it cannot be confident that the national medical board will be able to carry out its functions free from political interference, and in the best interests of the Australian people.

¹⁶ Consultation paper on proposed registration arrangements, section 9.2 (19 September 2008)

¹⁷ *Australia’s Health Workforce*, Productivity Commission, 2005, p.122

In New Zealand, there was an extensive debate about the appropriate balance between professional and statutory regulation. In the end the New Zealand government decided that all decisions and policies requiring clinical, ethical and professional knowledge should be made by the registration authorities rather than Ministers. This includes accreditation and monitoring of educational institutions and setting standards for clinical competence, cultural competence and ethical conduct. As a consequence, their Act does not give the New Zealand health minister power to direct a registration authority on any matters of policy, but merely to audit the processes used by the registration authorities to arrive at their decisions. This arrangement has maintained an important separation between political views and appropriate professional self-regulation.

The role of the National Agency

ASOHNS is also concerned that, over time, the role of the National Agency could evolve into one where the Agency also has an inappropriate influence on medical profession standards. Indeed, without explicit legislative protection, the National Agency could even interfere with decisions on individual registration applications and/or accreditation of particular courses. The proposed scheme does not have sufficient clarity about the decisions that the National Agency can and cannot take, or any assumption that it will be prevented from interfering with any of the professional operations or decisions of the health profession boards.

The cost of the scheme

The scheme is complex, cumbersome, bureaucratic and expensive. It will result in significant increases in registration fees for the health professions because it must be self-funding¹⁸. For some professions and individuals this cost could be prohibitive and discourage rather than encourage participation in the workforce. While governments have made some provision to cover the cost of implementation, we understand that the initial costing of \$19.8 million for implementation is already escalating.

Resources

There is a risk that the new national health professional boards will not be sufficiently resourced to adequately carry out their functions. While the National Agency may enter into agreements with the boards on their annual budgets¹⁹, there is no guarantee that the medical board will be provided with adequate resourcing to enable it to carry out its functions. This is partly because there is substantial work currently provided free of charge by individuals within the medical profession in the setting of medical standards.

We are also concerned that the cost of bureaucratic structures, and additional agencies and layers of oversight will have to be borne by the profession through increased registration fees once the scheme is operational.

¹⁸ Clause 12.3 of the IGA

¹⁹ Paragraph 21(1)(b) of the Act

AMA Alternative model supported by ASOHNS

(Terms of Reference E and F)

Having set out our concerns with the COAG proposed scheme, the following discussion outlines the AMA's preferred model for registration of medical practitioners and accreditation of medical education and training, a model which ASOHNS supports. The model has three essential components, which build on existing arrangements, maintain a high level of protection of the public and prevent the lowering of quality and standards.

1. Endorse nationally consistent accreditation of medical education and training through an autonomous medical accreditation body with specific medical expertise

- All health ministers and boards agree that a medical education and training accreditation body with specific medical expertise will have ongoing responsibility for setting national accreditation standards for medical education and training in Australia.
- The operation of this medical accreditation body will be independent of government, the medical schools and the medical profession (see section below on autonomous accreditation of medical education and training for further detail).
- All health ministers and medical boards agree to recognise (for the purpose of registration) the accreditation decisions made by the independent accreditation body in respect of individual courses of medical education and training, on an ongoing basis and without policy direction or interference from health ministers.

2. National registration of individual registrants through immediate development of a National Database and reciprocal registration arrangements

- Existing state boards continue to operate under state legislation, appointed by state governments/ministers with medical profession involvement in appointments.
- State boards continue to register practitioners in the state, and to perform complaints management/handling functions. The boards will employ their own staff to do this.
- In respect of practitioners registered in other states, existing state boards deem reciprocal registration of all registrants in other jurisdictions by virtue of inclusion of all state registrants on a new national register.
- Seek formal agreement for all states to have arrangements in place for existing medical boards to do this by an agreed date (e.g. 1 Dec 2009). Most states already have mutual recognition arrangements
- Reciprocal recognition arrangements would be implemented through revised state fee setting arrangements, and data and information exchange between existing state boards and the administrative arm of the new National Board to facilitate the compilation of the national register. There would not be multiple registers.
- Each doctor only registers once in their state of 'primary registration', where a majority of their practice is undertaken. All other states then 'deem' them to be registered.

- Registrants would only pay one registration fee for primary registration. Deemed registration would incur a minimal fee, to cover the administrative costs of the new National Board and its administration.
- Appropriate information from the national register is publicly available.
- Registrants are subject to statutory registration conditions determined by the medical board in the primary registration state.
- Registrants are also subject to the codes of conduct, discipline etc of the state in which they are practising at any time.

3. Ongoing harmonisation of registration standards

- Formation of new national board arrangements comprising:
 - chairs from all state boards and other appropriate representatives, who form the new National Board; and
 - administrative support staff for the new National Board responsible for maintaining a virtual national register and providing administrative support for the national board
- the National Board would perform the function of a “national registration standards authority” responsible for negotiating, housing and disseminating new national medical registration standards, and disciplinary approaches, and advising Health Ministers on appropriate legislative changes or common standards for registration, over time;
- State based legislation would be retained;
- Each state would still be responsible for keeping their legislative structures and embodying any nationally agreed registration standards in their state legislation by amending their legislation as they consider appropriate.

This model would provide a means of achieving uniformity on key aspects of medical registration without compromising state autonomy in relation to subsidiary matters. It would involve minimal additional cost for the new National Board and its administration, with existing roles/responsibilities of state boards and authority of state parliaments being retained.

ASOHNS believes this model can be implemented quickly and at minimal cost. It is also a model that could be applied to other health professions.

Under the proposed scheme, the National Board will be remote from the local needs of communities, and responses to complaints and concerns will be slowed by the nature of the distance and the size of the bureaucracy.

Autonomous accreditation of medical education and training

Given that one of the most significant concerns with the proposed scheme relates to the lack of independence of accreditation and standard setting, it is important to spell out here what we believe is essential to ensure that this independence and autonomy is retained.

Firstly, an autonomous process for developing and setting accreditation standards would provide no opportunity for policy direction to be issued by ministers, bureaucrats or any other agency on standard setting or amendment to advice on standards. The national board would not have authority to set standards, but rather

have responsibility to ensure that the standards are set through an appropriate process. Therefore, this would be a delegated responsibility from the national board to the accreditation agency, in order to satisfy the national board's responsibility for ensuring that setting of standards for accreditation is being undertaken for the medical profession.

Secondly, the accreditation agency for the medical profession (the AMC) needs to be an autonomous body, able to determine its own operations and processes under the scrutiny and direction of its own internal accountability structures as a separately incorporated entity. It would undertake these functions by way of delegated authority from the national board in order to satisfy the national board's responsibility for ensuring that the processes of accrediting individual education and training courses are being undertaken for the medical profession.

Thirdly, ministerial authority would be contained to formally acknowledging the standards which are set by the accreditation agency and the advice and recommendations provided by the accreditation agency in respect of individual education and training courses after assessing those courses against the accreditation standards.

Finally, all delegations to the accreditation agency (including for standard setting and assessing individual education and training courses) could include additional agreed quality assurance activities in respect of the operations and processes undertaken by the accreditation agency. Further, as is currently the case, there would be a high level of public transparency around the operations and decisions taken by the accreditation agency.

Separation of registration and accreditation functions

The registration functions should be administered separately from accreditation functions. The Productivity Commission held that there should be separate governance arrangements for registration and accreditation of professions because “it would be good regulatory practice to separate the setting and verification of standards at the education and training institutional level from the application and maintenance of standards in relation to individual practitioners”²⁰.

Combining the registration and accreditation functions will provide a vehicle to systematically lower standards for medical education and training and professional medical practice. The AMA alternative model ensures a clear separation of these functions.

Operational costs

It is important that medical boards are adequately resourced to undertake their functions, yet be administratively cost efficient as “user pays” organisations. The AMA alternative model provides a streamlined structure based on existing cost efficient arrangements.

²⁰ *Australia's Health Workforce*, Productivity Commission, 2005, p.122

Other terms of reference

The following discussion provides AMA comment on terms of reference not already covered in this submission. ASOHNS endorses these comments.

Impact on state and territory health services

(Terms of Reference A)

The AMA has long advocated for improved working conditions in the public sector health care, particularly public hospitals. State and Territory health services will attract qualified medical practitioners and other health professionals if they offer attractive working conditions, and ensure ongoing capacity to provide services to meet demand.

The greatest risk to a negative impact on state and territory health services is a spiralling decline of the quality of the workforce if the scheme permits a proliferation of underqualified medical practitioners to practice unsupervised, or non medically trained health professionals to practice beyond their education and training. It is inevitable that an under trained health workforce will result in an increase in adverse events. Qualified medical practitioners repeatedly called upon to manage adverse events will eventually leave the sector, only to be replaced by another underqualified health professional.

The result will be a second tier health system whereby people who cannot afford private health services have no choice but to seek care from underqualified health professionals who are employed by the state-run public system.

Further, under the proposed scheme individual health ministers will actually have less power to respond to local workforce issues. Instead, responses to local workforce issues will require consensus across all health ministers. In the AMA's alternative model individual health ministers will retain existing powers through the retention of state registration boards and acts of Parliament.

Impact on complaints management and disciplinary processes

(Terms of Reference D)

As previously stated, the proposed scheme is bureaucratic and cumbersome. In that regard it will be less responsive to the needs of the people than the existing arrangements. For example, if a local committee of the National Medical Board identifies a particular problem as part of an investigation of a complaint against a doctor, the local committee will not be able to resolve it without reference to the National Board. After it is considered and resolved by the National Board it will be returned to the local committee for implementation. The local committees will be less empowered to immediately protect patients.

The manner in which complaints are investigated and managed in each state has developed in response to specific local circumstances, decisions of local tribunals and

courts or local developments in areas of practice. The familiarity of patients and registrants with the underlying basis for legislation or legislative change is an important element to ensuring confidence in the system. As such, while the AMA would seek to ensure the most appropriate mechanism for the management of complaints, we note that this may well differ from state to state. The assessment of the “best” system must consider the confidence that patients and registrants will have in an externally imposed system.

Under the AMA alternative model, individual states and state boards would be able to retain existing arrangements, which have the confidence of the local profession.

The medical profession has led the way in finding models to ensure the management of practice is addressed in a broader fashion than just the response to complaints. The development of health programs for doctors has helped retain valuable skills and workforce, and has helped to develop a culture of greater openness about impairment issues.

State boards and associations have strong views on the relative merits of their existing differing performance and health systems. It is not our intention to comment on this other than to emphasise that amendments to any program must not compromise the confidence of registrants in that state.

It is critical that any complaints handling system affords natural justice and procedural fairness to both the complainant and the registrant. Failure to provide fair, just and transparent systems reduces the confidence of patients and registrants and results in longer complaints processes, more legal action and dissatisfaction.

To date, we have not seen any further detail on the legal framework for the complaints handling and disciplinary processes to be incorporated into the scheme.

For example, there is no detail about the application of the rules of evidence, the rights of the registrant including the right to choose not to respond to avoid incrimination, the right of the registrant to access or be provided with evidence and the consideration under which decisions of appropriate or inappropriate practice will be made.

There is also a lack of clarity around rights of appeal, the grounds upon which appeals of decisions may be made and where such appeals should be directed. It appears that the intention is to maintain the existing tribunal or court system in each state²¹ but to impose upon that tribunal a broad set of principles or requirements.

There is also insufficient information about the processes to be followed by specific complaints panels. This is covered in detail in existing state legislation and would need to be clearly specified in any primary legislation underpinning a national system to provide certainty and transparency.

²¹ Clause 6.8 and Item 1.25(l) in Attachment A to the IGA

The AMA considers this issue is of such importance to warrant specific details about what is actually being proposed being provided to the health professions to allow proper consideration of and consultation on the government's proposals.

Legal Representation

Legal representation is critical to ensuring procedural fairness for registrants. It is therefore not acceptable to expect a registrant who is facing the potential loss of, or restriction of, their registration to represent themselves in such an environment. Accordingly, with the exception of NSW, all states provide for legal representation before professional standards committees, although relevant legislation is currently before the NSW Parliament.

Government has not provided any information in the consultation papers to provide us with any certainty that the right to legal representation in the proposed complaints handling and disciplinary processes.

Mandatory Reporting

Doctors understand their responsibilities to their patients and to the patients of their colleagues. Considerable work has gone into developing codes of ethics and programs that encourage doctors and other health professionals to be more open about health and impairment issues. Programs that recognise addiction and impairment as health issues have encouraged doctors to self-report, obtain treatment and return to productive careers.

The AMA notes that on 5 March 2009 Health Ministers agreed to mandatory reporting of professionals who are placing the public at risk of harm. The communiqué cites cases of practitioners practising under the influence of drugs or alcohol, or sexual misconduct. However, no further detail has been made public.

Any consideration of supplementing existing requirements with new mandatory reporting requirements across the health professions as part of this scheme would require extensive consultation on much more detailed proposals with health providers and the community. There are considerable risks that health professions will not report at all if mandatory reporting requirements are expanded inappropriately.

Further, there should be no limitation on access to appropriate advice through medical defence organisations (insurers), where the advisors are typically medical practitioners or to legal representation. Insurers require their members to advise them early of any complaint, disciplinary or investigative process lodged or commenced against the member.

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