Australian Medical Association Joint Submission on National Registration and Accreditation, September 2008

Executive Summary

This joint submission is made by the Australian Medical Association (the AMA), the Australian Society of Ophthalmologists, the Australian Orthopaedic Association, the Australian Association of Surgeons, the National Association of Specialist Obstetricians and Gynaecologists, the Council of Procedural Specialists, the Australian Society of Orthopaedic Surgeons, the Urological Society of Australia and New Zealand, the Australian Society of Anaesthetists and the Australian Society of Otolaryngology Head & Neck Surgery (the co-signatories).

We support national registration arrangements and consistent standards for the medical profession across Australia. We support the scheme's[1] objectives of ensuring that only suitably trained and qualified medical practitioners are able to practise. We welcome reduced red tape for medical practitioners who seek to work in more than one jurisdiction.

However, we are very concerned that, in the context of a workforce reform agenda, the architecture of the scheme will permit the lowering of professional standards with consequences for patient safety and quality of care. We can find no evidence or justification for the model of accreditation of medical education and training and clinical standards setting proposed by the Council of Australian Governments (COAG) and delivered via the Intergovernmental Agreement (the IGA). Accreditation of the medical profession already exists and is applied in a national framework. We do not support the current COAG proposal as outlined in the IGA and other documents.

The AMA and the co-signatories have seven major areas of concern in respect of the fundamentals of the IGA:

1. Accreditation of medical education and training will not be independent of government, providing the potential to lower standards and therefore compromise patient safety and health outcomes.

2. Loss of the independence of accreditation of medical education and training will mean that Australia will no longer meet international guidelines.

3. The scheme will provide a vehicle to implement an unacceptable policy agenda of workforce reform, without scrutiny, evidence or public debate on changes to the roles and responsibilities of health professionals. Our fundamental concern is the potential impact on patient safety and health outcomes.

4. There is considerable risk that registration requirements and professional standards and competencies will be changed inappropriately and without public and professional scrutiny.

[1] The National Registration and Accreditation Scheme for the Health Professions

5. There is insufficient accountability for Ministerial decisions and policy directions, particularly when those decisions are inconsistent with advice provided by the professional board or the independent accrediting body.

6. There is a risk that the new national health professional boards will not be sufficiently resourced to adequately carry out their functions.

7. The scheme will result in significant increases in registration fees.

We are concerned that the safety and quality of patient care will diminish and health outcomes will be adversely affected by the scheme.

We believe that registration functions should be administered separately from accreditation functions. The medical profession is concerned that combining these two functions will provide a vehicle to systematically lower standards for medical education and training and professional practice. We have seen in some states situations where state government employers either did not check the registration status of a proposed employee, even though the medical board had placed a restriction on the doctor's practice, or failed to advise the board of the circumstances under which a proposed employee would be working. Consequently, public sector employers have allowed medical practitioners, who had previously been prevented from certain practice arrangements, to work in the public sector in response to short-term workforce supply problems (for example: 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).

The Productivity Commission's report put forward the view 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" (*Australia's Health Workforce*, Productivity Commission, 2005, p.122). This is not reflected in the final IGA, nor will it be provided for in the new legislation.

The current medical boards exist to protect the public. The new national medical board must maintain that function. To do this, the medical board will need to maintain high standards for:

- registration of medical practitioners; and
- the added responsibility of accreditation of medical education and training courses to deliver quality doctors for registration.

At the same time, the medical profession will need to be confident that the board is able to carry out its functions free from political interference, and in the best interests of the Australian people.

We believe that there is a real risk that the new scheme will erode the medical board's ability to protect patient safety, because the Ministers will be able to interfere in standard setting and in the policies of the board in order to meet perceived workforce imperatives. There is also potential that the new National Agency that will administer the scheme will, over time, influence and interfere in the setting of professional standards.

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. The IGA does not uphold this principle, and in fact defines that the Ministers can determine policy.

In the context of a broader workforce reform agenda, the risk to the safety and quality of patient care is heightened 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". This provision in the IGA (paragraph 5.3(e)) 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".

This therefore introduces two types of risk: firstly, lowering of medical standards; and secondly, allowing other "health professions" to practice in areas that are currently limited to the training and skill set of medical practitioners. In regards to the second point, this broader agenda for widening the scopes of practice for non-medical health professions has not been explained to the Australian public.

The AMA and the co-signatories remain committed to maintaining excellence in medical practice in Australia. We believe this could be achieved through administrative reform of the existing framework, without any compromise to patient safety and quality outcomes. This is not the approach governments have chosen to take.

This submission is provided to inform government about aspects of the scheme that require more detailed consideration to ensure patient safety and quality is paramount. It provides strategies that could be incorporated into the legislation to mitigate the risks. While we provide recommendations to address our concerns, our submission does not imply our concurrence with the final outcome. Our final view on whether the IGA delivers an acceptable model will depend on whether the protections we have suggested are included in the legislation. It will also depend on how closely the final scheme reflects the existing framework and protects the public interest.

Major areas of concern

The following discussion sets out the joint position of the AMA and the co-signatories in respect of our major concerns and provides recommendations for addressing those concerns.

1. Independent accreditation of medical education and training

National accreditation of medical education and training in Australia already exists and is provided by the independent Australian Medical Council (the AMC).

The independence of accreditation of medical education and training in Australia currently meets international guidelines (refer item 2. below). This independence will no longer be protected under the proposed scheme. This is because nationally Ministers, not boards, will have final approval of, and be able to issue policy directions on, accreditation standards.

Accreditation of medical education and training should be independent of any political process. The public's confidence in the accreditation process to deliver the highest standards

of medical education and training, and consequently patient safety and quality care, must be protected. This requires a process that legally *obliges* Ministers to take advice from an independent accrediting agency via the national medical board. To achieve this, we believe that the independent accrediting body should have formal delegated authority in respect of accreditation standards as well as for decisions to accredit individual courses.

Further, there should be clarity about exactly what functions and decisions the National Agency can take. To guarantee that there is also no interference from the National Agency in respect of accreditation standards, the legislation should contain explicit provisions that preclude the National Agency from making decisions about accreditation standards.

If the independence of the accrediting body is not retained, there is a real risk that standards for accreditation of medical education and training could be eroded and manipulated. This is because Ministers will be able to change professional and accreditation standards to address workforce issues or achieve cost savings. For example, shortened training courses could be encouraged. Through policy directions from Ministers on accreditation standards, short courses could then be accredited in future as a means of introducing a rapid process for bringing people into the health workforce.

The lowering of medical standards and competencies, and the substitution of medical practitioners with other classes of health professions for workforce reasons or cost saving cannot be supported. Australia can afford to maintain its highly trained and highly skilled health 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.

To satisfy the degree of independence for accreditation of medical education and training that is required, the following criteria would need to be met:

- It must be delegated to a body with sufficient medical professional expertise; and
- There should be a legislated requirement for further consultation and dialogue with the medical profession prior to any decision that is not totally consistent with the recommendations of the accrediting body.

The AMC is the independent national standards body already established for the purpose of accrediting medical education and training, providing advice on the recognition of medical specialties and advising on the maintenance of professional standards in the medical profession.

In addition, relevant specialist colleges are responsible for prevocational and specialist training and for setting, monitoring and assessing professional competencies and standards. There is voluntary accreditation of the colleges training programs by the AMC.

There is no case to be made for dismantling the independent process of accreditation of medical education and training. Nor is there a case to be made for replacing the role of colleges in the setting of medical standards and professional competencies. Governments should ensure that the new medical board formally assigns or delegates responsibility for providing expert advice on the accreditation of medical education arrangements for the first 3 years of the scheme to the AMC and that the medical colleges are responsible for the development and assessment of medical practice competencies.

Recommendations

- The AMC should be assigned the responsibility for accreditation of medical education and training for the first 3 years of the scheme.

- Any ministerial decision in relation to the accreditation role for medical education and training beyond this period should ensure that an independent body with specific medical expertise undertakes this role.

- Any ministerial decision to allocate the accreditation role for medical education and training should not be taken without explicit and extensive consultation with the broader medical profession, including relevant professional associations, in addition to the consultation with the national medical board that is already required under the IGA.

- Further, in relation to Ministerial decisions about accreditation standards, professional standards and competencies, the legislation should include specific provisions such that:

  - Ministers are only able to approve standards and competencies after receiving recommendations from the independent medical accreditation body and relevant specialist colleges on the matter under consideration;

  - there is a requirement for further input from the medical profession and a period of public consultation prior to any final Ministerial decision being made on such issues that is not totally consistent with advice provided by the independent medical accreditation body and/or the relevant specialist colleges.

- Any provisions in the legislation, subordinate regulations or operational guidelines relating to continuing professional development (CPD) should be framed in such a way as to ensure that responsibility for designing and administering CPD in respect of the medical profession remains with the relevant specialist colleges and is not transferred to, or duplicated by, the medical board or any other body.

2. Accreditation will not meet international guidelines

The accreditation of medical education and training in Australia is founded in a legal framework that meets the World Health Organisation/World Federation for Medical Education *Guidelines for Accreditation of Basic Medical Education* (Geneva/Copenhagen 2005). Under these guidelines, 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.

As stated above, Ministers, not boards, will have final approval of, and be able to issue policy directions on, accreditation standards.

If the new legal framework does not meet the international guidelines, as is proposed under the new scheme, this may impact on the high standing of Australian trained doctors and their ability to work in other countries. Under the current arrangements, courses accredited by the AMC are recognised by the United States Department of Education.

The proposed scheme also puts at risk the standing of international medical students studying in Australia.

Recommendation

- Approval for accreditation of medical education and training under the scheme should be implemented in such a way as to ensure that it complies with the World Health Organisation/World Federation for Medical Education guidelines.

3. Policy agenda of workforce reform

Bringing together responsibility for the approval of both registration and accreditation standards under Ministers will enable health workforce reform by stealth. The architecture of decision-making under the scheme, as set out in the IGA and proposed to be enshrined in the new legislation, will facilitate future changes in roles and responsibility across the health professions without evidence, scrutiny or public and professional debate.

The AMA and the co-signatories are concerned that there is no requirement in the IGA for one professional board to consult with other boards and engage other affected professions prior to any decision to expand a particular profession's scope of practice. As the IGA is written, each professional board will be able to make recommendations in respect of their own education and training and scope of practice in a silo. They have absolute discretion about who and how and whether they consult at all. There is also no requirement for Ministers to consult with other professions when approving changes to competency and practice standards for each health profession.

The New Zealand experience, following the introduction of one national health professions registration Act, demonstrates what can happen in the absence of a clear legislated requirement for boards to consult each other on these issues. Some of their health profession registration authorities (equivalent to the Australian new national boards) have made decisions to expand the scope of practice for that profession without appropriate consultation with other relevant health professions, including the medical profession. For example, midwifery services were expanded without any reference to the medical profession and without any clear evidence base around the impact on safety and clinical outcomes for patients. This has introduced significant uncertainty about the lines of responsibility for patient care and increased risk in respect of health outcomes for patients.

The same could apply when a totally new health profession seeks recognition and registration status under the new Australian scheme. Once that new national scheme commences, any new professional group should only be able to be registered on a national basis. Further, the legislation should expressly preclude States and Territories from introducing any new classes of health profession registration in their jurisdiction alone through state legislation. In addition, there should be a legislated requirement under the scheme that other health professions are consulted on any proposal to register a new health profession, including on the scope of practice for that new profession.

Further, State and Territory legislation authorising health professions to possess, administer and prescribe scheduled medicines must not be incongruous with the scope of practice determined under the scheme.

In summary, if Australia is to maintain a highly skilled and integrated health workforce, there must be consultation between the professions on the relevant scopes of practice.

Recommendations

- There should be a requirement in the legislation that governments have transparent public consultation processes and formally seek the views of the medical profession before agreeing to allow other registered or unregistered health professions to independently undertake any activities that are currently only allowed to be undertaken by, or under the supervision of, a medical practitioner.

- There should be a requirement in the legislation that state and territory governments must seek the views of the medical board before making any amendments or additions to the existing provisions in state and territory drugs and poisons legislation regarding pharmacists, nurses and allied health providers who are authorised to possess, administer and prescribe scheduled medicines.

- There should be a requirement in the legislation that governments have transparent public consultation processes and formally seek the views of all existing registered health professions before agreeing to recognise and register any new class of health profession through the scheme.

- Any new class of health profession should only be introduced and registered under the national scheme, and only after extensive consultation with existing health professions. New classes of registered health professions should not be able to be registered on an ad hoc basis by states and territories outside of the scheme once the new national scheme has commenced.

4. 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 will be changed inappropriately 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 junior doctors, such as core terms for interns. These core terms place a compulsion on state governments in respect of clinical training arrangements 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 through guidelines.

The AMA and the co-signatories believe that, in order to ensure changes to registration requirements and professional standards are subject to public and professional scrutiny and debate, they must be incorporated into primary legislation in the second Bill (Bill B).

Recommendation

- The primary legislation should contain specific registration requirements and professional standards and competencies.

5. Accountability of Ministerial decisions

Under the parameters set out in the IGA, while Ministers will not approve the actual list of accredited courses, they will have final approval of profession specific accreditation standards. Similarly, while Ministers will not approve individual registration decisions, they will have final approval of registration, practice and competency standards and continuing professional development requirements. These decision-making and governance arrangements are intended to be reflected in the new legislation.

The AMA and the co-signatories are very concerned that the scheme will result in Ministers setting standards for the medical profession that lower the highly trained and highly skilled medical workforce that Australia currently enjoys.

In this context we note that 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 proposed Australian scheme does not have sufficient legislative protection in terms of the transparency, accountability and review of decisions or directions made by Ministers. This is particularly important where those decisions may be inconsistent with advice from the professional board, the independent accrediting body or the profession itself.

We are very concerned that Ministers will be able to influence the board's decisions by issuing policy directions on workforce or training issues generally as well as standards and competencies.

In the interest of patient safety and quality of care, there must be a requirement in the legislation for a process of consultation and formal review prior to Ministers taking any decisions that are inconsistent in any way with the advice of the medical board or the independent accrediting body.

We are also concerned that, over time, the role of the National Agency could evolve into one where the Agency also has an inappropriate influence on the accreditation and professional 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. The role of the National Agency must be articulated in more detail and the legislation must ensure that the Agency is explicitly prevented from interfering with any of the professional operations or decisions of the professional boards.

Recommendations

- The legislation should be explicit about the decisions that Ministers can make and what they can approve.

- The legislation should set out a process to be followed when Ministers:
  - do not agree with advice or recommendations from boards; and/or
  - do not agree with decisions made by boards; and/or
  - decide to give directions to boards unrelated to any recommendations or advice they have received from boards.

- There should be transparency in any ministerial decision-making process. This should include a requirement in the legislation to undertake a formal consultation and review process involving input from the profession before any final decision is made which is inconsistent in any way with advice received from the professional boards.

- The legislation should be explicit about the decisions the National Agency can, and cannot, make.

6. Adequate resourcing for the medical board

There is insufficient protection under the proposed governance arrangements to ensure that the new national medical board will be provided with the necessary resources, both financial and human, to do its job.

Further, there are ancillary functions (e.g. scholarships, counselling and research) that many health professional boards currently undertake that will need to be factored in when determining adequate resourcing for the new national boards.

In the short-term, we understand that there may also be additional costs associated with managing the transition of the current staff of the existing boards. Government officials have advised there is a prospect that <u>all</u> current staff will be immediately employed by the National Agency for their respective national board. While we acknowledge that this would help ensure a smooth transition and continuance of service by the new national boards, it also means that the purported efficiency gains of the scheme will only be realised once there is natural attrition of staff, and only if they are then not replaced.

We understand the logic of this proposal, but believe that these additional transitional costs should be fully borne by governments and not passed on to the professions. We also expect that if this unexpected staff transition approach is adopted, the transitional cost obligations of

governments, as set out in the IGA, should be extended beyond the two-year commitment in the IGA.

In the longer term, we are concerned that it could be difficult for the new national boards to implement workable staffing arrangements. This is because the IGA specifies that it is the National Agency that will employ the staff of the professional boards, not the boards themselves, even though the staff will then be under the direction of the national boards. In addition, we consider that the legislation must include a mechanism to ensure that the national boards are provided with sufficient resources to undertake their work.

The legislation must therefore contain a process for ensuring that national boards are able to set their budgets and that the National Agency must take these budgets into account in allocating funding. There should also be appropriate avenues for appeal by national boards if they are dissatisfied with decisions of the Agency.

Recommendations

- All transitional costs should be borne by governments.

- The legislation should include a mechanism to guarantee that the professional boards are provided with sufficient resources to undertake their work.

- This should include the following explicit requirements in legislation:

  - a formal budget setting process to ensure that the professional boards are integrally involved in decisions about their staffing and other resourcing; and

  - a formal process to ensure that boards have input into employment issues such as appointment/termination of individuals, resourcing and defining the roles and responsibilities of their staff; and

  - formal review and appeal processes for boards if they are dissatisfied with resourcing decisions of the National Agency. These processes should also provide an opportunity for input from professional associations and organisations of the relevant health profession.

7. Increased registration fees

The Government has said that there will be efficiencies with a national scheme covering all health professionals. However the AMA and the co-signatories believe that the scheme will be cumbersome and more costly to administer than the current arrangements. Already, as stated above, there is a proposal to transfer all existing board staff to the new national boards, which will significantly reduce any efficiencies under the new arrangements. The additional costs of the scheme will be an additional cost to the health system and consequently the taxpayer.

The National Agency and its subsidiary entities are new entities with new government-imposed processes and policy roles. It is not reasonable for governments to impose the costs of these additional entities on the professions. Therefore, governments should fully cover the establishment costs and ongoing running cost of them (including the operating costs of

national offices and associated one-stop shops). The professions' registration fees should be limited to the cost of running their respective professional boards.

The medical professions' fees should be quarantined and only used for the cost of operating the medical board and associated disciplinary processes.

If it transpires that the national boards are more costly to operate than the current arrangements, then Government should be required to meet the shortfall in operational expenses.

Recommendations

- Governments should fully cover the establishment costs and ongoing running cost of the National Agency and its subsidiary entities, including the operating costs of national offices and associated one-stop shops.

- The medical professions' fees should be quarantined to cover only the cost of operating the medical board and associated disciplinary processes.

- Any increase in registration fees for individual medical practitioners:

  - should be limited to that which is necessary for the ongoing functioning of the medical board only, not any other part of the scheme; and

  - should not increase at all over and above existing fees in the first year of operation; and

  - should not increase by more than CPI in any subsequent year of operation.

- The legislation should require governments to meet any shortfall in operating expenses of the medical board and associated disciplinary processes.

Other matters

The AMA and the co-signatories have provided our comments on other aspects of the scheme, including matters related to the establishment of the national medical board, at Attachment A.

Conclusion

Contrary to Government views about the level of detail that should be included in the first Bill to implement the scheme, we believe the issues set out in this submission must be addressed in the primary legislation. It is critical that patient safety and quality of health care remain paramount and are protected in the longer term through appropriate governance, transparency and accountability in the legislation underpinning the new registration and accreditation arrangements.

The scheme is being introduced rapidly and, in its current form, runs a significant risk of lowering standards and therefore compromising patient safety and health outcomes over time. Our recommendations are in the interest of securing patient safety through the maintenance of the highest standards for the medical professions.

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Attachment A

Australian Medical Association and co-signatories comments on other aspect of the scheme

Name of advisory council

- We believe that regardless of the name of the advisory council, it will not obscure what its function will be and its proposed effect.

Advisory council office bearers

- The legislation should specify that at least one member of the advisory council should be a medical practitioner.

Name of the medical board

The medical board should be named the *Medical Practitioners Board of Australia*.

Size and composition of medical board

As stated previously in this submission, the medical board exists to protect the public and therefore high standards need to be maintained and ensured into the future. The medical profession needs to be confident that the medical board is free from interference to carry out its functions. In order to achieve this, the following principles should be followed in determining the composition of the new national medical board:

- The Chair should be a practising medical practitioner with significant seniority and recognition in the medical profession.

- Two thirds of the members of the medical board must be medical practitioners.

- All of the medical practitioners on the medical board should be practising and have appropriate experience, expertise, seniority and acceptance within the profession.

- The medical practitioners on the medical board, and the board's committees should include a general practitioner, a rural general practitioner, a psychiatrist, a surgeon, a general physician, and an obstetrician/gynaecologist and a practising senior medical administrator.

- We note that the IGA states that members of the board will be independently appointed and not represent any professional body or organisation. However, we believe that a proportion of the board should be comprised of people directly elected by the profession. We consider that such election is necessary if the board is to continue to hold the trust and confidence of the medical profession it regulates. We note that, following consideration of this issue by the New Zealand Government, they included provisions in the original New Zealand Act to allow the Minister of Health, following consultation, to make regulations that allowed for the relevant authority to hold elections to elect a portion of the membership to the authority. We contend that similar provisions should also be included in the new Australian legislation

- The majority of the members of the profession boards should be health professionals who are currently regulated by that board and are currently in practice or teaching. This will ensure that governments do not appoint health professionals to the medical board who may not have the requisite contemporary knowledge of medicine to participate effectively.

Ministerial power to review composition of boards

- Composition of the medical board must always be at least 2/3 medical practitioners (in addition to the chair who should also be a practising medical practitioner). This should not be subject to review. Any other changes to the composition of the remaining 1/3 of the board should only be made after a fully transparent public consultative process and the requirement for this consultative process should be set out in the legislation.

- To facilitate this, there should be a requirement in the legislation that, if the Ministers intend to review the composition of the medical board under the IGA, they must consult with the profession both during the review and prior to any final decision being taken to change the composition of the board.

Sitting fees and other remuneration for board members

- Currently, in respect of the medical profession, a substantial amount of work on the development of practice and competency standards is undertaken by medical practitioners on a probono basis.

- Given that there is no certainty that this will continue under new scheme, governments should factor remuneration of expenses for this currently unfunded activity into budgeting forecasts for the medical board under the scheme.

- In addition, reasonable sitting fees and other remuneration for participation in board, committee and disciplinary processes should be factored into the medical board's budget and properly resourced by the National Agency.