



# No Compelling Case for COAG/IGA model of National Registration & Accreditation<sup>1</sup>

## Executive Summary

*Australia's health system has many strengths. Overall the health outcomes compare quite favourably with those in other developed countries. For example, Australians have among the highest life expectancies in the world - including when 'disability adjusted' for years of 'good health'. Yet total spending on health care as a percentage of GDP and per capita is not overly high by advanced OECD country standards (AIHW 2004a).*

Ref: Australia's Health Workforce, Productivity Commission Research Report, 22 Dec 2005

The Australian medical profession is a national asset. It stands to reason that any substantial intervention to the way it functions as an independent profession must be justified in the public interest.

The proposals put forward by COAG do not meet such a test. They arise from the writings of Professor Stephen Duckett, who claims that current pressures on the delivery of Australian health care can be largely attributed to a lack of central planning by government. Where is the evidence to support this claim? The COAG-IGA proposal is a house built on sand – a claim without evidence.

Prof Duckett's work can be seen in the COAG-sponsored Productivity Commission Report, which made numerous recommendations for increased central planning functions over the medical workforce, but failed to provide any substantive evidence that such changes would improve workforce productivity (it stated it could not measure productivity) or lower health costs. The lack of cost/benefit analysis for such widespread proposals is breathtaking.

Furthermore, the COAG model sees the introduction of intermediaries between the doctor and the patient, in the form of allied healthcare professionals with wider scopes of practice. Such policies would introduce into Australia a two-tiered health system, where direct access to a doctor is substituted by the use of lesser-trained gatekeepers (patient assessors), particularly for those with limited ability to pay.

Under COAG's proposals, accountability for medical outcomes is transferred from state medical boards to COAG agencies. Patients with grievances will find increasing difficulty in obtaining parliamentary accountability for medical and healthcare standards, as health ministers direct complaints to the COAG bureaucracy.

Administrative reforms (a national register and simultaneous registration) can be achieved through the current structures at minimal cost to the Australian taxpayer whilst maintaining public confidence in an independent and world class profession. The COAG/IGA proposals hold out strong prospects of weakening the ability of the Australian medical profession to deliver quality care by blurring distinctions between doctors and other professions and by removing valuable training opportunities at a time when record numbers of doctors are set to graduate from universities.

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<sup>1</sup> This submission is written in response to the impact of the COAG IGA National Registration & Accreditation Scheme in respect of the Australian medical profession although the points may impact on other areas, the submission does not claim to speak outside of the medical profession.



## No Compelling Case

1. The Inter-Governmental Agreement for a National Registration and Accreditation Scheme for the Health Professions **binds all states and territories and the Commonwealth to a system whereby nine professions are administered by a Ministerial Council and its various authorities**. These include: an Australian Health Workforce Advisory Council, a National Agency, an Agency Management Committee, National Boards, Board Committees, a Registration Agency, an Accreditation Agency and an External Complaints and Review Processes Agency.  
*"Given that in the order of 400 000 health professionals may eventually need to be accommodated, involving some nine professions and potentially 90 registration bodies, the scale of this task is substantial."* (Ref: Response to the Second COAG Consultation paper on a National Health Professions Registration and Accreditation Scheme, Australian Medical Council, (undated))
2. The Australian Doctors' Fund (ADF) finds **no compelling public interest case to justify the interventions** being proposed by COAG/IGA and subsequent legislation as it relates to the medical profession.
3. The ADF notes the work of Prof Stephen Duckett, former senior public servant in the Federal Department of Health and advisor to Qld & Vic state governments. In particular we note his following papers:
  - **Health Workforce design for the 21st Century, Australian Health Review, May 2005**
  - **Interventions to facilitate health workforce restructure, Australia & NZ Health Policy, June 2005**
4. The ADF notes that the **COAG Inter-Governmental Agreement (IGA) cites as its raison d'être the recommendations of Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005** (Productivity Commission Report).  
*"Following the release of the Productivity Commission's report Australia's Health Workforce earlier this year, the Council of Australian governments (COAG) requested that work be undertaken on the report's recommendations, including those relating to health professional accreditation and registration."*  
(Ref: Second Consultation Paper: Proposal for a National Registration Scheme for Health Professionals and a National Accreditation Scheme for Health Education and Training, (undated) p. 2/19)
5. Given the central importance placed on the Productivity Commission Report, its contents and recommendations need closer examination.
6. **The Productivity Commission Report was commissioned by COAG** and its recommendations used as a justification by COAG for the proposals, now being implemented into legislation.
7. The ADF notes **16 references to Prof Duckett's work in the Productivity Research Report**. The ADF also notes that **many of the recommendations in the Productivity Commission Report follow Prof Duckett's proposals** in respect of the above 2 papers (see Point 3).  
*e.g. "One strategy to encourage flexibility in the workforce would be to increase the range of items which do not require personal provision by, for example, designating all procedural items in this category. In this way, for example, an anaesthetist would be able to bill for the work of a nurse anaesthetist using the anaesthetic items of the Schedule. Assuming salary costs for the substitute professional are lower than the medical specialist, this would then put*

*a financial incentive on medical practitioners to utilise other health professionals for service delivery. It may also be appropriate to allow some **consultation items to be billed without personal provision.***”

(Ref: Prof S J Duckett, Interventions to facilitate health workforce restructure, Australia & NZ Health Policy 2005, 29.6.05)

**Recommendation 8.3 Productivity Commission Report**

*The Australian Government should increase the range of MBS services for which a rebate is payable when **provision is delegated by the (medical or non-medical) practitioner to another suitably qualified health professional.** Where delegation occurs:*

- a. **the service would be billed in the name of the delegating practitioner; and***
- b. **rebates would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.***

8. Given that Prof Duckett’s papers pre-date the Productivity Commission Report and the many similarities between Prof Duckett’s writings and the Report’s recommendations, **the ADF claims that Prof Duckett’s views are the platform upon which the IGA/COAG proposals have been built.** It is therefore essential that the justification supporting Prof Duckett’s claims for a substantial re-engineering of the health professions, particularly the medical profession, be critically examined.
9. **Prof Duckett claims that workforce shortages in most health professions in Australia are to due to “lack of appropriate structures for health workforce planning”,** and not basing planning needs “*on identifying skills shortages*”. (Ref: Prof S J Duckett, Interventions to facilitate health workforce restructure, Australia & NZ Health Policy 2005, 29.6.05,p1)
10. Professor Duckett gives **no weight to the fact that the demand for health care services will always outstrip supply,** when those services are free to the user, or significantly subsidised.
11. Contrary to Prof Duckett’s claim that a failure in central planning is to blame, the ADF contends that health economist Roger Kilham’s analysis needs greater consideration: “**Health spending is rising inexorably, like a vice-grip. One jaw is demand, driven by rapidly rising expectations and an ageing population. The other jaw is the supply effects from new health technologies. Cross-contamination occurs. New health technologies lift expectations.**” (Ref: Health Under Labour, Roger Kilham, Access Economics, AMA Federal Conference, Hobart, 30.5.08)
12. The ADF contends that given a rapidly increasing demand for medical and allied healthcare services (as evidenced by Medicare transactions now running at almost 300 million per annum, and increasing at 8% per annum) **demand side considerations cannot be ignored when discussing workforce shortages.** (Ref: Table 1.1 - Medicare by Broad type of service and various periods, 2008Q2, www.medicareaustralia.government.au)
13. As new subsidised Medicare services are introduced, their utilisation escalates, eg **optometry now produces 6 million transactions per annum,** ie the equivalent of over 30% of the Australian population transacting with an optometrist once every year. (Ref: Table 1.1 - Medicare by Broad type of service and various periods, 2008Q2, www.medicareaustralia.government.au)
14. Furthermore, evidence from the **centrally planned British National Health Service model shows massive workforce dislocation,** including large numbers of trainee doctors and qualified nurses unable to find positions, while shortages exist in other areas. History shows that central planning rather than removing workforce distortions will exacerbate them. (Ref: Newly-trained nurses can’t find jobs in NHS, International Express, 1 April 2008)
15. Furthermore, in the Australian case, the **Productivity Commission notes no significant undersupply of Australian health workers in comparison to other countries.** “*In*

*comparison to most other OECD countries, Australia does not appear to be significantly undersupplied with health workers. For example, on a doctor to population basis, Australia is not markedly behind in regard to practising medical practitioners”* (Ref: Australia’s Health Workforce, Productivity Commission Research Report, 22 Dec 2005, p 339)

16. **Sweden** presents a further example of the **failure of central planning**, *“In 1975 an average doctor met nine patients a day. Today it is down to four. **People have to wait for months or years to get basic surgery**, with huge human and economic costs as a result. What kind of welfare is that?”* (Ref: Maria Rankka, Competition, Trade key to Prosperity, The Australian, 12 Jun 2008)
17. The ADF contends that **Prof Duckett’s claim that greater central planning is the remedy for Australia’s future health care workforce needs rests on shaky ground**. This is further evidenced by Prof Duckett’s cautious choice of language to support his claims.
18. Prof Duckett concludes ...  
*“Contemporary **perceived shortages** of most categories of health professionals; Health workforce is **probably not** suitable for 21<sup>st</sup> century healthcare; The problem is **usually** couched in terms of workforce supply; Specialisation now seen as **possibly** detracting from continuity of care and hence **may have deleterious impact on quality**; Current assignment roles for health professions is **perceived to be inefficient”***  
(Ref: Prof S J Duckett, Interventions to facilitate health workforce restructure, Australia & NZ Health Policy 2005, 29.6.05,p1)
19. **The ADF does not believe the above constitutes a firm empirical foundation** on which to build substantial change to the current models, which have served the public interest in terms of parliamentary accountability for professional conduct (see Point 26).
20. Furthermore, the ADF maintains that **some of the proposals being advanced in terms of task substitution are dangerous to the public in that they increase the risk of greater mortality** particularly in areas of anaesthesia and surgery, which have enjoyed high standards of safety in comparison to comparable overseas environments. *“As you well know, anaesthesia training in Australia takes a minimum of 13 years and results in Australian anaesthesia being the safest in the world. One of the main reasons for that safety is that anaesthesia is provided by highly trained medical practitioners who are exclusively dedicated to one patient”* (Ref: Dr Greg Deacon, Past President, Australian Society of Anaesthetists, Open letter to the Council of Procedural Specialists, June 2005)
21. The ADF maintains that there is ample evidence that the end result of **workforce changes as proposed by COAG would result in a two-tiered health care system**.

Pressure to reduce costs will see greater scope of practice being given to allied health care and **doctors’ services being rationed through the use of ‘patient assessors’**. Those in greatest economic difficulty are likely to find their access options restricted. This will be dressed up as “co-ordinated care” or “team-based care”.

This process is already underway with the **importation by the Queensland government of physicians’ assistants from the US managed care system**, whose role is broad and undefined.

*“And so it’s about preparing people from a variety of backgrounds to be able to assume a **flexible locally negotiated sort of medical extension role**, working with the doctor and with a sort of an **evolving responsibilities and skills** on the basis of a sort of general qualification.”*  
(Ref: Prof Richard Murray, Dean of Medicine, James Cook University, 6.30 ABC Radio, North Queensland, 13/8/08)

22. New gatekeepers are also envisaged, which would restrict patients' direct access to a doctor. *“Such multi tasking could for example focus on assessment functions where a **single practitioner (be they nurse or allied health professional) undertakes a comprehensive assessment of a client’s needs on behalf of all members of the care team.**”*  
(Prof Stephen J Duckett, Health Workforce Design for the 21st Century, Australia Health Review, May 2005, p 207)
23. The ADF maintains that **some Australian universities looking to increase revenue could be expected to support any number of new “product lines” in health care** with the promise of attracting high fees from young people keen to advance what they see as new career paths in clinical health care. However, in practice, such an expansion is likely to create unmet expectations in fee-paying students when it is realised that meaningful training opportunities which are already under pressure become even scarcer.
24. The ADF cannot find any evidence that the recommendations contained in the COAG/IGA for the medical profession will result in savings to the healthcare budget from the implementation of the new structures. **Prof Duckett advances no cost benefit analysis in his papers, nor does the Productivity Commission supply any independent financial costing** in its report.
25. The ADF finds no evidence of productivity gains or efficiency gains through the implementation of the COAG agenda and in particular a workforce agency imposing task substitution. **Claims of productivity gains are undermined by the conclusion of the Productivity Commission that it could not even measure health workforce productivity, “Overall, currently available information does not support the full assessment of health sector productivity and hence the efficiency of health sector provision.”**  
(Ref: Australia’s Health Workforce, Productivity Commission Research Report, 22 December 2005,p.387)
26. The ADF asserts that **claims that COAG/IGA legislation and subsequent structures are necessary because of notable cases of doctors being accused of clinical abuse, are unfounded and misleading.** The NSW Medical Board has published assurances that current structures safeguard the public from the registration of interstate deregistered doctors, *“the de-registration or suspension of a doctor in NSW would be immediately recognised in any other Australian jurisdiction in which he or she were registered or seeking registration.”*  
(Ref: NSW Medical Board media release, 28 Mar 2008)
27. The ADF further asserts that in two of these cases **failure by government agencies or hospital administrators to follow standard procedures** of checking applicants and their credentials was central to the events that followed.
28. In terms of public accountability, rather than failing, the system worked. In prominent and **unfinished cases**, namely Dr Patel (Qld) and Dr Reeves (NSW) the **respective Ministers for Health being accountable to their constituents acted appropriately in calling for inquiries and requesting evidence as to substance, causation and remedy.** Hence the existing structures delivered public accountability as well as affording those accused due process in the defence of serious allegations. Far from being a failure of the system, these cases highlight the necessity for direct political accountability for the performance of health professionals in each state. The current system works, though often not to everyone’s satisfaction.
29. The ADF can find **no evidence that the proposals will lead to an alleviation of the rural medical workforce imbalance.**

30. The ADF maintains that the **COAG/IGA proposals to integrate physicians assistants and others in quasi-medical roles into the health workforce will reduce the training opportunities for existing and future medical students, and doctors-in-training and hence slow the absorption of skilled medial practitioners into the existing workforce.** Training places are at a premium.
31. The ADF notes that, contrary to popular belief, “mutual recognition” of medical qualifications has been in place for several years with beneficial results, *“the implementation of Mutual Recognition has resulted in a greatly streamlined system of medical registration across State and Territory borders. However significant barriers remain and doctors wishing to work in more than one jurisdiction are confronted with an unduly duplicative registration process.”*  
(A Model for Medical Registration, NSW Medical Board, June 2001)
32. The ADF believes that **the necessity to fill in one or more registration forms does not amount to “significant barriers”.** Nevertheless, **the ADF believes this administrative function can be streamlined (using web-based technology)** to achieve simultaneous registration into a national register making the expensive experimental new structures and agencies, as detailed in the **COAG proposals, redundant.**

## Recommendations

1. **That the Australian medical profession not be included in the current COAG/IGA plans,** legislation or regulation; and that the functions of State Medical Boards and the Australian Medical Council be maintained in their current state.
2. **That a web-based programme allowing for simultaneous registration in all states be introduced** and recognised in current state-based legislation, incorporating existing mutual-recognition principles.
3. That the current **state-based medical registers be integrated into a National Register,** ie that the Compendium of Medical Registries be upgraded.
4. That the **Council of State Medical Board Presidents continue to function as a national co-ordinating committee.**
5. That parliamentarians urgently **call for an independent cost-benefit analysis on all of the COAG/IGA proposals in respect of national registration and accreditation.**

## Conclusion

“There is no compelling case or public demand for changing the way doctors have traditionally been educated, trained and recognised. The national interest requires public confidence in the medical profession. **Any attempt to de-medicalise the Australian medical workforce will generate public anxiety and uncertainty at a time when Australians want security and predictability.** The COAG/IGA proposals should be rejected as there is no compelling case for their implementation.”

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