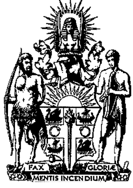

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29 April 2009

Mr Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery

Please find attached a submission from the Royal Australasian College of Surgeons to the Committee's inquiry into National Registration and Accreditation for Doctors and Other Health Workers.

This is a matter of great concern to Australian surgeons for, whilst we recognise considerable benefits in the proposed reforms, we also see real deficiencies – deficiencies that would undermine the quality of healthcare provided to the Australian community.

Accordingly, the College would appreciate the opportunity to appear before the Committee on its scheduled day of hearings to outline how the proposed arrangements could be modified to ensure that the eventual reforms represent a genuine improvement on existing healthcare arrangements.

Yours sincerely

Professor Ian Gough
President

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

A SUBMISSION TO THE SENATE COMMITTEE ON COMMUNITY AFFAIRS INQUIRY INTO

NATIONAL REGISTRATION AND ACCREDITATION FOR DOCTORS AND OTHER HEALTH WORKERS

NATIONAL REGISTRATION AND ACCREDITATION FOR DOCTORS AND OTHER HEALTH WORKERS

The Royal Australasian College of Surgeons welcomes the decision of the Committee to conduct an inquiry into the proposed National Registration and Accreditation Scheme (NRAS) for the health professions and appreciates the opportunity to make this submission.

Representatives of the College would be pleased to appear before the Committee and feel that this could assist Committee members in their consideration of issues that are of fundamental importance to the well-being of the Australian people.

Summary

At a meeting on 26 March 2008 the Council of Australian Governments signed an Intergovernmental Agreement (IGA) on the health workforce aimed at creating a single national registration and accreditation system for nine health professions, including medical practitioners.

While the College welcomes a national registration system, which among other things will enable medical practitioners to move around Australian states and territories more easily, we have serious reservations about some aspects of the proposed arrangements. These significant concerns have been raised clearly and forcefully in our submissions to the team charged with implementing the IGA but, thus far at least, appear to have been ignored.

Accreditation

The College is particularly concerned that proposed reforms to arrangements for the accreditation of education and training courses will compromise the quality of Australian healthcare. Specifically, we see an obvious conflict of interest in the proposal to delegate responsibility for both registration and accreditation to one body. Whilst national registration has a number of important benefits, these need to be kept separate from consideration of the standards of education and qualification required to achieve and maintain registration.

This concern of the College regarding accreditation standards and processes is shared by all representative medical bodies including the Committee of Presidents of Medical Colleges and the Australian Medical Association and indeed is of significant concern to all of the affected health professions.

It is most important that issues relating to standards are developed and monitored by an accreditation body that is independent of the registration board and free of political influence. The College would strongly oppose any arrangement whereby a committee comprised of public servants were delegated the task of accreditation. However well meaning such a committee, it would be subject to pressure from its political masters to lower the standards required to qualify as a health professional, in the mistaken belief that this would alleviate pressures on the health workforce. Put simply, such a committee might, over time, succumb to the temptation to put 'quantity ahead of quality'.

Our recommendations regarding accreditation are:

1. The accreditation standards body for each health profession must be independent of influence from the Registration Board and the Ministerial Council (or any alternative governing body of Health Ministers and/or health administrators);

2. The accreditation body must have the independence, expertise and authority to determine the training and qualification required for the relevant profession and the specialties within that profession; and

3. The Australian Medical Council (AMC) model should be replicated for all health professions, if necessary by staged implementation to ensure it is done properly.

Specialist Colleges
Throughout the consultation process the College has been dismayed to find no role for the specialist medical colleges in the proposed arrangements. Given the fact that the colleges have ensured world class medical care for generations of Australians, this is a serious omission. Coupled with the proposal to merge the registration and accreditation functions, this omission reinforces our concern that the IGA is seeking to increase the number of health professionals by simply lowering educational standards. The College believes that the Australian public expects and deserves a better way of relieving pressure on our health systems.

Office holders of the College have repeatedly raised this issue personally with senior officials responsible for the implementation of the National Registration and Accreditation Scheme. Despite assurances that the specialist medical colleges would figure in subsequent consultation papers, we have yet to see any evidence that the colleges will have a role beyond 2010 in respect of the registration, assessment, training or continuing competence of medical practitioners. The specialist medical colleges are first and foremost educational institutions – institutions of internationally recognised excellence – and we fear that bureaucrats charged with the task of producing more doctors consider this excellence an inconvenience.

Protection of Titles and Scopes of Practice
We support the protection of professional title and the identification of suitably trained and qualified professionals in a separate register of specialists. There are currently 13 such specialities of medicine recognised in Australia. However, protection of title without regard to scopes of practice is unsafe. Where there are overlapping scopes of practice (and there are many in healthcare) it should be mandated that the involved professions communicate and reach agreement. This is particularly obvious in high stakes areas such as surgery, invasive procedures and investigations, and in the prescribing of dangerous drugs.

The College also has concerns regarding the following particular issues.

Continuing Professional Development
The College supports the continuing professional development requirements of the individual professions, and the established role of the specialist medical colleges in the development and delivery of CPD courses.

Area of Need
No Minister or ministerial appointee should be able to designate a particular geographical area an “Area of Need” without reference to the appropriate specialist medical college as to the appropriate qualifications and experience required to practice safely and effectively in that jurisdiction and in the particular practice setting. The setting of standards in instances of medical “Area of Need” must be a medical, not a political, exercise.

Migrating Registrants to the National Scheme
Proposals to migrate registrants across to the national scheme with the widest scope of practice are dangerous where such scope and standards may not have been previously acceptable in other jurisdictions. The new national scheme must not adopt the “lowest common denominator” when seeking scopes of practice and standards from existing state and territory jurisdictions.

Surgery by Non-surgeons
Patient safety dictates that non-surgeons should not be able to perform surgery without the most rigorous consideration being given to their level of competence, by both the board of the particular health profession and the medical board, and with particular reference to the Royal Australasian College of Surgeons. We firmly believe that expert surgery should be performed by expert surgeons.

Disciplinary Processes
Disciplinary processes must be consistent and must be procedurally fair. Inappropriate public disclosure of complaints before their finalisation runs the risk of demonising the innocent and, in the process, undermining public confidence in the health system.

Mandatory Reporting
The College has concerns about proposals relating to the mandatory reporting of health professionals experiencing personal crises, and fears that these provisions will in fact deter people from seeking help. An impaired, untreated professional could be a significant risk to the public.

Information Sharing and Privacy
We also note with concern aspects of the proposed scheme relating to information sharing and privacy.

Specific Commentary

To assist the Committee's consideration of the proposed scheme, and the College's response to it, we have structured this submission in accordance with the Committee's published terms of reference.

a. The impact of the scheme on state and territory health services

The proposed arrangements would represent a surrender of authority on the part of state and territory health services, most notably in the area of professional registration and the oversight of professional conduct. Providing that any new arrangements represent an improvement on existing arrangements, the College has no objections to what would be, essentially, the centralisation of the registration function.

b. The impact of the scheme on patient care and safety

The Need for a Specialist Register
The College believes that a separate register for specialists is fundamental to patient safety, and has made this view known repeatedly. Despite these stated concerns, it is still proposed by the committee charged with implementing the IGA that specialist qualifications be entered against a practitioner's name on an integrated register.

We argue that the maintenance of a separate specialist register would ensure that specialist practice is only undertaken by practitioners with specialist qualifications that have been accredited by the AMC or, as is the case for overseas trained practitioners, those who have been assessed under an AMC accredited process as being substantially comparable to an Australian specialist.

The College strongly opposes the proposal to define specialist practice as a form of limited registration. Currently, and quite appropriately, specialist practice is viewed as an extension of expertise, enabling a practitioner to practice specialist medicine in addition to that medicine which can be practiced under general registration. It should be noted that many surgeons, particularly those practicing in rural Australia, also work across the breadth of clinical practice at some stage of their careers. It would be a severe blow to rural communities if new registration arrangements disallowed this practice. At a time of mounting pressures on the health workforce, new registration arrangements should serve to expand rather than limit a clinician's options and allow them to better serve their communities.

The College believes there should be a separate register for specialists and that this should confer rights of practice in addition to those conferred by General Registration. There should also be a formal distinction between specialist endorsement for college members and the endorsement of those with overseas qualifications who are not members of the relevant specialist college.

The Specialties
It is proposed by the proponents of the scheme that:

> "The Ministerial Council may issue guidance to boards in relation to criteria for the recognition of specialties under the scheme, including those specialties to apply from 1 July 2010".

The use of the word “may” fails to clarify arrangements and leaves open the possibility that guidance may not be issued or will be issued to some professions and not others. Any guidance provided by the Ministerial Council should be consistent for all health professions and limited to a framework of standards.

The appropriate body to determine and assess the training and qualifications that apply to a specialty is the accrediting body for the profession. This accrediting body, which in the case of the medical profession is the Australian Medical Council, must be allowed to function independently of influence from both the proposed Ministerial Council and the Medical Board of Australia.

Continuing Professional Development

The College notes the reference to “continuing competence”, terminology that we understood was to be revised following earlier discussions. Continuing professional development (CPD) is not the same as continuing competence. While we would support the development of continuing competence standards in the future, it is impractical to refer to standards that cannot be currently implemented and we would suggest referring instead to continuing professional development.

The College strongly disagrees with the assertion from those developing the NRAS that:

> “Minimum standards for continuing competence requirements for specialist endorsement must not be discipline specific”.

To have any credibility, continuing competence standards, or CPD, must be specialty specific and involve the specialist medical colleges where relevant. It seems both unrealistic and unnecessary to require, for example, surgeons and psychiatrists to meet the same requirements. The minimum requirement for common continuing professional development compliance for members of the same profession practicing in different specialties would be so low as to be meaningless. Unless the minimum standard involves the completion of a CPD program as determined by the recognised specialty, the College would strongly oppose this proposal.

Protection of Title

The College notes and endorses the protection of the term ‘medical specialist’. We raise, however, our firm belief that the term ‘surgeon’ or ‘surgical specialist’ should be similarly protected. The right to use the title ‘surgeon’ or ‘surgical specialist’ should be available only to those medical professionals on the specialist register without any restriction or condition on their specialist practice. Members of the public are entitled to know whether the person they are consulting is a surgeon who has undergone comprehensive surgical training or someone entitled to perform only a few, specific surgical procedures.

Area of Need

Proposals regarding area of need arrangements are opposed by the College. It has been proposed that the Minister in a jurisdiction:

> “have the power to ‘designate’ a particular geographic area as an ‘area of need’ with respect to the services of a particular regulated profession”.

No mention is made of advice or input from the profession and we recommend that this be incorporated.

The proposal that boards be empowered to judge applications for area of need registration against whatever standard they themselves have developed is strongly opposed. If the standard to apply to area of need applications is completely flexible, it represents no standard at all. Moreover, the reference to “a nationally consistent approach” leaves open the possibility that jurisdictions will seek to alleviate health workforce pressures by adopting the professional standards developed by the least rigorous jurisdiction. The very fact that the paper proposes the development of new professional standards suggests that existing standards of excellence are deemed too onerous. In the case of area of need specialist medical practice, advice from the relevant specialist group is essential; indeed it should be mandated, remunerated and indemnified.

'Areas of Practice'
It is proposed that boards and the Ministerial Council have the power to establish separate "areas of practice" which will be substantially more limited than either general or specialist registration. Whilst this may assist in those cases where an overseas trained surgeon has a specialty in, say, hand surgery or foot surgery, but does not have sufficient qualifications or experience to qualify fully as an orthopaedic surgeon, the College is concerned that this clause could allow other non-surgeons to carry out surgical work on the basis of this limited "area of practice" endorsement.
There should at least be a requirement that the Ministerial Council and the relevant board consult with the relevant specialist medical college before developing any guidelines for approvals in this area.

Those developing the NRAS have proposed that:

> "wherever possible registrants be migrated across to the national scheme with the widest possible scope of practice that is consistent with public safety. They would then be expected to practice within their competence..."

The College sees dangers in this proposal where lesser qualifications have been achieved by practitioners of surgery and where there is no scrutiny of standards across disciplines.

It is further proposed that each national board will determine:

> "how the current registration status of individual registrants should translate to registration under the new scheme, including to specialties that are recognised under the national scheme"

The College strongly opposes this provision where similar scopes of practice are to be undertaken. In such circumstances, there must be consultation between boards.

Surgery by Non-surgeons
The College could not support the registration as specialist surgeons of those who perform surgery but who do not have an appropriate surgical qualification. For example, we could not support the registration of specialist podiatric surgeons who do not have equivalence in their field of practice with the experience and training signified by Fellowship of the Royal Australasian College of Surgeons. The College would not support surgery being performed by podiatrists who have had their practice of surgery endorsed under the new scheme without review of their training and qualifications by the Podiatry Board and the Royal Australasian College of Surgeons as the body accredited by the Australian Medical Council and recognised by the Australian community as the standard setter in surgical practice. In order to ensure public safety there must be cross discipline review of qualifications to practice surgery.

Specialty Training Standards
Proponents of the NRAS have proposed that:

> "recognition of new specialties or specialty areas of practice on professional registers … be subject to the approval of the Ministerial Council."

The College believes that no new areas of specialty practice should be considered by Ministers without the notification of other health professional boards as a prerequisite step. It is considered important that this notification of other relevant national boards also be a prerequisite step in any consideration by the Ministerial Council of expansion of the range of courses to be offered.

The role of the medical colleges and the importance of recognised specialty practice must be incorporated into the legislation. Specialist registration is now a fundamental part of health sector regulation. The training for this needs to be provided by appropriate accredited bodies, and the issue of competence and performance within the designated specialties must involve not only the medical boards but also the AMC recognised medical colleges.

With regard to the assessment of International Medical Graduates, the College has for some time expressed its concern over the issue of legal liability. The College notes and welcomes the proposal that this activity be covered by the indemnity that the new accreditation processes will carry.

c. The effect of the scheme on standards of training and qualification of relevant health professions

The College notes the guiding principles for accreditation arrangements as enunciated by the Ministers. The College strongly supports these and has itself always been guided by them. It is imperative that these principles are guaranteed by legislation in any new accreditation arrangements.

Autonomy
Those developing the proposed accreditation arrangements have also highlighted one important principle:

> "The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession."

It should be noted that this principle is in accord with papers produced by the World Health Organisation, the World Federation for Medical Education and Professions Australia which appropriately profile the key principles of separation, autonomy, involvement of the profession and rigour that will be vital to any proposed Australian system.

It is essential to the credibility of any system that the accreditation of courses and the registration of the professional be quite separate processes across all the professional groups. The principle of autonomy must be guaranteed in the legislation if there is to be any confidence in the system.

Furthermore, confidence in any new arrangements must be global. Unless the resultant system accords with international guidelines for the accreditation of education and training courses, we run the risk of compromising an Australian trained clinician's capacity to practice abroad and the international status – and attractiveness – of Australian medical education. It is important at this point to note the benefits flowing to Australian patient care from a clinician's exposure to new practices and procedures in other parts of the world.

Professional Representation
The College notes with dismay the tendency toward lessening the involvement of the professions in their own regulatory and accreditation arrangements. NRAS proponents have stated:

> "Membership of the accreditation panels should not over-represent the interests of the profession".

This begs an obvious, but unanswered, question: How do you define "over-represent"?

For the new systems to work, and for professional and public confidence in them, it is imperative that the chair and the majority of members of key committees be drawn from the relevant health profession. If necessary, committees need to be able to register dissenting views. Professional confidence in the system's commitment to public safety is critical, and the issue of membership will underpin any such confidence.

Australian Medical Council
The role of the Australian Medical Council has been acknowledged a number of times in the NRAS documents and there is a mechanism available to ensure it can serve as the accreditation body as the new arrangements are implemented. However, the medical profession needs greater certainty that this will indeed occur.

Moreover, the College believes strongly that there should be an ongoing and central role for the AMC in any new arrangements. The profession, the current medical boards, the universities and the medical colleges have all worked closely with the AMC to achieve the benefits of the existing system. This needs to be more than merely acknowledged – the processes that achieved these benefits need to be built into the developing system.

The Role of the Specialist Medical Colleges
The College of Surgeons remains very concerned that the role of the medical colleges is not properly recognised in the provision of accredited training, and this needs to be corrected in any eventual legislation. The colleges are central to the provision of accredited postgraduate vocational training as well as to the assessment of international graduates who have

specialist qualifications. While the College understands the challenges posed by the variation in practice across the ten health professions, a one-size-fits-all response is not acceptable.

d. How the scheme will affect complaints management and disciplinary processes within particular professional streams

The College supports a nationally consistent process, fully transparent and fair to all parties involved, for the handling of complaints against doctors, as well as dealing with performance, competence and impairment.

If the national system is to be successful then the development of consistent terminology and processes for the handling of complaints across the jurisdictions is paramount. However, the methodology and processes for current complaint handling differs markedly from jurisdiction to jurisdiction. The approach in New South Wales, for example, is substantially different from that in most other states and territories.

Accordingly, the College is concerned that a nationally consistent approach will not be maintained if the processes dealing with complaint handling, impaired doctors and competence are actioned through local bodies that have developed their own processes, priorities, standards and attitudes. Any national system will necessarily have to deal with the substantial differences that presently exist across jurisdictions.

Further evidence of this is the failure of the proposed arrangements to address the integration of the new system with existing Health Complaints Commissions. The use of Health Complaints Commissions to mediate and conciliate complaints is a useful part of the overall complaint handling system. Many complaints originate through Health Complaint Commissions, and are not referred to medical boards. This option should be maintained. The proposal for mandatory notification exchanges between the new medical board and Health Complaints Commissions is unnecessary, and complainants should be able to choose whether they wish to proceed through the Health Complaints Commission, or with an official notification to the national board.

It is the College's view that the proposal does not adequately deal with the inter-relationship between existing complaint handling bodies and the medical colleges, which have long had an important role in dealing with the performance and conduct issues of their own Fellows. The colleges provide support to medical boards in relation to performance assessment, independent reviews of practice, and other reviews.

Provision should be made to continue indemnification of the Colleges in relation to any assistance they may give to the national board, or to the state and territory boards and tribunals, when carrying out reviews or assessing performance on behalf of these bodies.

The proposed structure is such that under the national board will sit four committees. The College notes that the make up of these 4 committees is not clear at this stage.

The committees are:

- Notifications assessment committee;
- Performance management committee. This committee will have powers to *"oversee the management of practitioners whose performance may be unsatisfactory"*. There is an argument to be made that, in the case of Australian surgeons, the proposed responsibilities of this committee, including performance assessment, are already and very effectively exercised by the College through its Executive Director for Surgical Affairs;
- Health management committee; and
- Conduct management committee.

The College strongly supports identification of underperformance, and health and conduct problems in the workplace with a view to remediation and preservation of the practitioner in the workforce. Prevention rather than response should be the objective and although it is stated that there is a focus on prevention and early intervention, it is obvious that complaints handling is the true focus. There needs to be significant investment in ongoing performance review by properly resourced peer–reviewed audit. The College has an established record in this activity and has recently published a document on assessment of competence and performance (available at www.surgeons.org) that could be adapted for all health professions.

The College supports the proposal for the national board to have the power to suspend the registration of a medical practitioner where there is an established risk to public health and safety. However, the proposal to allow suspension where "potential risk" exists needs more serious consideration. The level of evidence and certainty required should be substantial, before suspension of a medical practitioner occurs. A fully transparent process, with natural justice and procedural fairness, is required.

Appropriate review of a suspension decision must be provided for. The process whereby serious complaints are to be referred to and adjudged by tribunals, or other mechanisms in each state and territory, rather than through a nationally consistent process, has the potential to produce inconsistent decisions from jurisdiction to jurisdiction. The attitude, process and procedures of state and territory based boards and tribunals varies markedly and can therefore lead to inconsistent decision making in relation to similar complaints – and thus prevent a nationally consistent approach to these issues. The state and territory based boards or tribunals should be subject to nationally consistent rules, standards and process requirements.

The College has some concerns regarding mandatory reporting obligations. Specifically, one proposed option would force a treating practitioner to report a registrant who may have various health complaints or substance abuse problems. While the College recognises the purpose of this requirement, it raises the fundamental issue of doctor-patient confidentiality. It could also serve to discourage a registrant with potentially serious health issues from seeking care. A registrant, concerned that his or her livelihood will be jeopardised by a treating doctor's obligation to report, could opt instead to continue practicing and, in so doing, place patients at risk Any proposed processes for mandatory reporting should be specifically available for public comment and review.

The College also supports a process in which the doctor's name and reputation is preserved and protected, until such time as an adverse finding is made. The impact of intrusive and sensationalist reporting on a doctor's reputation and practice can be substantial, and accordingly the protection of a doctor's name and reputation should be a paramount feature of any new system. Disclosure of a doctor's name should only be made when adverse finding is determined, or disclosure is necessary for reasons of public safety.

While notifiers are to be protected from defamation, malicious prosecution or conspiracy charges, what recourse do practitioners have to protect their reputation from frivolous or malicious allegations? The College believes that if the notification has been made public, it would be fair if there was public disclosure of a decision by the board not to proceed.

The proposal to develop a "responsible board" which will appoint persons to notifications assessment committees, using a "list of persons who have been approved by the Ministerial Council", raises obvious and critical questions. Who will these approved people be, from what areas will they be drawn, and what expertise will they bring to the proposed committees? The College hopes that at least some of these persons would be health practitioners involved in clinical practice.

Again, the proposals regarding assessments afford no role whatsoever for specialist medical colleges. Given the colleges' record of excellence, this is a serious oversight.

It is recommended that this proposal is revised to specify that a majority of the panel is from the same profession as the registrant, and in the case of a medical practitioner on the specialist register, must contain a member from the same specialist register.

The College strongly supports closed hearings.

The College supports the categories of information proposed being made publicly available, with the previously noted preference for a separate specialist register. However, we would recommend that once a suspension is served, that this information be removed from the register. We would also expect that, as with the Victorian register, voluntary conditions on practice would not be noted.

It is proposed that the legislation provide for the names of practitioners de-registered for conduct reasons to appear on the public register, along with an indication that they have been de-registered for conduct reasons. This appears to be unduly harsh. We do not agree that it is necessary to provide such detail for an indefinite period on a public register. Rather, the

College would support other options, such as including de-registered practitioners on the register with a status of de-registered but without specifying that the cause is conduct related. Alternatively, they could be removed from the public register altogether. Either of these options would serve the same purpose, without further humiliating the deregistered practitioner.

The College believes clarification is required regarding those practitioners who are deregistered for reasons other than conduct being removed from the register.

Clearer definition regarding the test for release of a practitioner's health conditions would need to be provided before the College could agree to this. Our preference would be for the register to contain the names of practitioners who are unrestricted and those who are restricted. While the restriction itself should be in the public domain, the reasons for that restriction – whether health, performance or conduct related – need not be on the publicly available register.

The College does not support the routine release of tribunal decisions where no adverse finding has been made. In these cases, the test of "in the public interest" should not apply. An important exception would be when the fact of an ongoing tribunal investigation has already been made public; in the event that there is no adverse finding, natural justice would dictate that this information be made public and the practitioner's reputation be restored.

The College would agree with the proposal to remove old decisions from the register when they are no longer relevant.

While the College would support the provision of information to the relevant authority where a practitioner has caused, or is causing, a significant threat to the life or health of any person, we could not support the provision of information for such ill-defined reasons as "not complying with 'professional standards'" without thorough investigation. It is imperative that the legislation tightly define the reasons for release of information by the Professional Services Review.

e. The appropriate role, if any, in the scheme for state and territory registration boards

The proposed arrangements effectively abolish state and territory registration boards. If state and territory jurisdictions object to this proposal, to the point of threatening the prospect of national registration, the College would support a system whereby a national registration authority served to co-ordinate state and territory registers, ensuring health professionals could move between jurisdictions with the same ease that would be afforded by one, national register.

f. Alternative models for implementation of the scheme

Given our support for a system of national registration, but our opposition to proposed arrangements for accreditation as they currently stand, the College would support a phased introduction of any new scheme. Once a national system of registration, or at least a nationally co-ordinated system of registration, was in place, attention could then be turned to the development of a system for the accreditation of education and training courses that in no way compromises the independence of, or public confidence in, the accreditation process.

Such a phased approach would not only facilitate the transition to a new system, but would help ensure that the resultant system represented an improvement on existing healthcare arrangements.

Conclusion

The Royal Australasian College of Surgeons welcomes reforms to Australia's healthcare system that represent genuine improvement, and accordingly supports the principle of national registration. At a time when Australia's health workforce is hard pressed to meet the demands of an ageing population, any measures to facilitate the movement of professionals between Australia's jurisdictions are to be welcomed.

However, if one of the effects of the new arrangements is to exclude the institutions which currently ensure world class health care for Australians – institutions such as the Australian Medical Council and the specialist medical colleges – we can only conclude that the purpose of the these arrangements is to ease pressure on the health system by lowering the standards required to become a health professional.

The Australian public expects and deserves better.