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Licensing: Political Control Over Access

ABSTRACT: It is inevitable that a licensing process controlled by government must sooner or later result in the exploitation of the process to serve political ends. It ought also to be unsurprising when deliberate attempts to restrict entry to a particular trade or profession raises prices and creates turf wars whilst achieving very little in terms of patient safety. Regulatory controls inhibit innovation and they prevent patients from gaining access to a wider range of treatment options. In the case of health care, the features of a centralized licensing process are predictably exacerbated when they are combined with a universal taxpayer-funded health system. When government finds that it is simply impossible to fund all the health care promises that it has made it necessarily restricts access to care on a collective basis – including access to the best trained providers.

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Men are valued not for what they are but for what they seem to be.
E. G. Bulwer-Lytton

The preference of most doctors for socialized health care is influenced by their belief that individuals can and ought to be protected by those who know better from the bad choices they may make. A preciously guarded view is that licensing is a useful way to achieve that end. Those who have been licensed also benefit from

the 'coincidental' anti-competitive effects flowing from the restrictions on entry that licensing involves.

While, as I shall argue, licensing has never produced the benefits claimed for it, the damage that it caused was limited when it was operating in a more market-based system. The defects of the licensing system have become much more apparent in a socialized system in which the process has been usurped and exploited by government in an attempt to manage its failures to ensure an adequate workforce and to pay for the services it has promised.

The centralizing tendency of authoritarian regulatory controls has been extended to the creation of a national licensing authority covering a wide range of health professionals. Government has made a hopeless mess of the conversion from a state-based to a federal-based system and doctors are now starting to realize that a choice of jurisdictions may act as a constraint on the excesses of any one jurisdiction (since individuals can often simply move between jurisdictions) and that the problems of licensing across jurisdictions could have been more simply resolved by a system of reciprocal recognition. By gaining increased control of the licensing process the national government now has firmer control over the standards of health care professionals in addition to the financial controls exercised through the subsidies it provides.

Sad to say, these changes have all occurred with the active connivance of the profession's medico-political leaders – generally because they support the philosophical basis on which they have been made. Rather than reflect on the wisdom of the beliefs that have led to this point, the principle focus of professional leaders has been merely to complain about government's inefficiency and its willingness to relax the anti-competitive protections previously awarded exclusively to the medical profession.

Strangely, despite the considerable costs of implementing a licensing (and ongoing accreditation) system nobody seems to think that its outcomes require justification. Yet, the large number of studies in the literature examining the relationship between quality and licensing are about equally divided between supporting and denying the relationship (or show no relationship at all).

This paper will argue that licensing does not achieve the goals claimed for it as evidenced by the large number of malpractice claims that are still being made and the reality that it is this same licensing process (supposedly to protect the "public interest") that is now being used to underpin the "market" entry of a wide range of "less-safe" complementary and alternative practitioners - all of whom will, of course, be registered and licensed.

I. THE EFFECTS OF LICENSING

One clue as to the effects of licensing, as the Friedmans have pointed out, is that those who lobby for the introduction and extension of the licensing process are "invariably representatives of the occupation in question".[86] This is because becoming licensed not only provides a competitive advantage for the licensed but it is a necessary prerequisite for eligibility for the subsidies that government provides exclusively to the clients of licensed service providers. The removal of a subsidy, the development of a new one or the transfer of a subsidy from one professional to another can significantly alter the case-load and the income earning capacity of a profession or trade.

Licensing laws tend to be enacted because those engaged in a particular profession or trade are more concentrated politically than the consumers of their product. As Hans Sennholz has observed, the licensing process has always been a route to riches. Even in the 17th century,

> training and examination of physicians was a serious government matter. Under the watchful eyes of the government, ancient quackery was to be perpetuated. In some cases, persons with no training whatsoever were practicing the business of healing and offering salves and medicaments because they curried favour with the inspectors, or succeeded in winning over the lackeys, valets, mistresses, and adventuresses of the Court. Royal charters, permits from princes, and acquired titles of physicians of the king or queen, of surgeons of the navy, and the like, sanctioned all kinds of quackery. The methods of favoritism, currying favors, obtaining franchises, licenses, or government orders have not changed materially since the seventeenth century.[87]

As well as opening up the process to political abuse, licensing almost always raises the cost of the service rendered, provides the basis for turf wars between different groups of service providers and by restricting the number of available professionals creates the very circumstances in which substitution affects are most likely to occur and charlatans are able to flourish. The medical profession, in an attempt to justify higher fees and to inhibit potential competitors, has always enthusiastically

86 Milton Friedman and Rose Friedman, *Free to Choose* (Penguin, 1981) 281.

87 Hans F. Sennholz, 'Progress or Regress' in Bettina Greaves (ed) (The Foundation of Economic Education, 1975) 263.

embraced this process and has progressively raised the barriers to entry (by requiring, for example, increasing course lengths, continuing professional development, certification to perform particular services and the accreditation of practices) - all in the name, of course, of increasing the quality of care in the "public interest".

Restrictions on entry, however, reduce the incentives for medical practitioners to compete with one another on either the price or the quality of the service provided. Moreover, as Mary Ruwart has observed, "the negative impact of decreasing availability far outweighs any increase in quality that may occur".[88] Studies have demonstrated that eye care is poorer and blindness more common when there are fewer optometrists, dental hygiene is worse when there are fewer dentists and accidental electrocution is more common when licensing requirements for electricians increase.[89] And who can doubt that the quality of medical care decreases as physicians becomes less available?

Licensing negatively impacts on the overall quality of care when, by preventing unlicensed practitioners from performing tasks that they are perfectly capable of performing, licensed practitioners are compelled to spend time doing things that do not fully utilize their skills (and the number of available professionals is effectively reduced). By requiring uniformity and compelling compliance with the accepted wisdom of the day, licensing can also have serious effects on innovation and progress. The uniformity that results from the licensing process is also undesirable when what a consumer wants in a professional varies, as it frequently does, with the individual consumer.

Licensing laws actually put people at risk, in the same way as do advertising laws, by lulling them into a false sense of security about the quality of the service provided. Patients are inclined to believe that their interests are well protected and that they do not need to bother with the sorts of precautions that they would otherwise normally take.

Furthermore, in spite of the claims that licensing and registration protect the public, the medical profession itself contains a large number of practitioners who deliver services that are little different from those attributed to charlatans - except that registered practitioners are often able to bill Medicare for their non-medically recognized treatments.

Charlatans aside, it is clear that licensing has also done very little to protect consumers from the large number of doctors who remain in practice despite being

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88 Mary J. Ruwart, *Healing Our World: The Other Piece of the Puzzle* (SunStar Press, 1992) 55.

89 Sidney L. Carroll and Robert J. Gaston, 'Occupational Restrictions and the Quality of Service Received' (1981) 47 *Southern Economic Journal* 970.

only marginally competent (or frankly incompetent). Reviews of patients receiving hospital, obstetric and ambulatory care continue to show that they are frequently the victims of medical mismanagement.[90] Similarly, a former Pennsylvania commissioner of insurance estimated that 15% of America's dentists were either incompetent or dishonest and that dentists extract six million teeth a year that could be saved through other treatment.[91] A few of these incompetent practitioners will be brought to the attention of the licensing authorities when they commit some more obvious blunder but the vast majority operate below the radar. Their patients simply receive unsound advice on a wide range of matters and have their illness processes inadequately managed. The idea that continuing professional development (CPD) solves this kind of problem is also not supported by the facts. Not surprisingly, more competent physicians enroll in more CPD courses and there is no way to ensure that those who attend because they have to will participate in a way that ensures that they actually learn something. In fact, the range of activities that are allowable as continuing medical education sometimes makes a mockery of the entire concept.

Even if the licensing process did offer some marginal protection to the public it must be asked "at what cost?" How, for example, can the enormous costs involved in continuing professional development (CPD), which must be passed on to the consumer, be justified when, as most commentators agree, CPD is of such doubtful benefit in changing performance?

II. LICENSING IN AUSTRALIA'S SOCIALISED SYSTEM.

The introduction of a universal health care system has not only produced additional stresses but it has made more obvious the deficiencies of the existing licensing process. Instead of being paid by patients and being committed to their interests, doctors have become increasingly dependent on the State for their incomes and have had, therefore, to consider government's interests in every patient interaction. Irrespective of claims to the contrary, doctors are required to follow the directions of government and to tackle the problems of "society" (using politically correct methods) rather than of their individual patient. As a result, they have increasingly

90 Gary L. Gaumer, 'Regulating Health Professionals: A Review of the Empirical Literature' (1984) 62 *Milbank Memorial Fund Quarterly/Health and Society* 395.

91 Stanley J. Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (Greenwood Press, 1984) 35.

become the victims of intense resentment and sometimes even violence at the hands of their patients.

The absence of a patient who is personally responsible for the costs generated in the majority of medical interactions has led to the creation of a complex billing and surveillance system that has damaged patient confidentiality, made a potential criminal out of every doctor (and medical receptionist) and seriously harmed the doctor-patient relationship. As well as controlling access to various investigations and treatments, doctors are now required to act as the government's policeman, approving access to various subsidies and privileges and engaging in a variety of whistle-blowing activities involving both patients and colleagues. Traditional doctors have lost a great deal of respect as they have become increasingly engaged in the interrogation of personal lifestyle choices, the pursuit of "easy" government money (generating income, for example, by completing useless care plans) and the rationing of health care. The medical profession's preoccupation with the delivery of a uniformly high standard of care has often made it appear as if doctors would prefer that patients received no service at all rather than one provided by a person not trained to the highest possible, medically approved standard.

Many of these changes have been accompanied by the conversion of previously voluntary professional ethical codes into legal obligations in Medical Practice Acts and by alterations to the content of those codes. Medical ethical codes have had to be changed, for example, to compel doctors to take account of the costs they might impose on the system.

As well as co-opting doctors to assist with funding difficulties, the licensing system has been used to address workforce problems that are an inevitable accompaniment of a system in which services are free at the point of delivery and where practitioner time is wasted performing services that are attractively rebated but that consumers do not value. Doctors in training and overseas trained doctors are compelled to work in areas of need and the workforce is deliberately re-configured to include licensed service providers without traditional medical training.

The role played by allied health practitioners in the medical workforce has widened because of lobbying pressures exerted by the practitioners themselves and because governments have been unable either to solve workforce problems or to adequately fund the services they have promised. Since almost nobody questions the underlying ideological premise that it is a legitimate part of government's role to deliver health care services, arguments for or against a change in the system have been limited to the associated safety and cost advantages or disadvantages of

the particular proposal rather than whether or not it is desirable to have a licensing system at all.

A. Nurse practitioners and midwives

In introducing lesser trained personnel to the “market” government has attempted to lower the costs of care and deal with the shortage of doctors while avoiding the politically damaging suggestion that there will be any reduction in service quality. An advantage to government is that the shorter training times required to produce these alternative providers enables more flexibility in manipulating the workforce and doctors who enter into disputes with their political masters can be more easily brought into line by threatening to replace them with alternative providers (as happened in one of the initial Nurse Practitioner Projects). While the medical profession will countenance no decrease in training requirements for *its* members the same effect (an overall reduction in training requirements) is being achieved by introducing a range of non-medically trained providers. And while the training offered to nurse practitioners (and chemists and so on) will improve, it is unlikely to attain the standards reached in traditional medical courses. Ultimately it becomes a matter of semantics whether the persons delivering health care services are called physician assistants, up-skilled nurses or down-skilled general practitioners.

Under normal market conditions better trained service providers will usually be more expensive since they must be compensated for the opportunity costs that their training involves (and if superior intelligence is required, for the higher incomes they can earn elsewhere). However, since we do not have normal market conditions it remains doubtful whether the introduction of less extensively trained providers of medical services will actually lower costs. It is likely, for example, that many of the services provided by Nurse Practitioners (NPs) will be new services and not simply substitute for those previously provided by doctors. Since these services will be subsidized under Medicare, they will also be subject to overutilization in the same way as are the services of medical practitioners. Furthermore, the rebates (and therefore basic fees) for the services offered by NPs are currently equivalent to those awarded to non-vocationally registered doctors (and will eventually exceed them since NP rebates are indexed and non-VR rebates are not). Nevertheless, the nursing lobby has already complained that their rebates are not high enough![92] It seems that the reluctance to train more doctors based on the view that they are cost generators for the system may be a concern that will ultimately

92 ‘Rebates not enough for nursing groups’ (November 2010) *Primary Care Nurse* 3.

be transferred, possibly with even greater force, to NPs. It has already been revealed that NPs provide a far greater proportion of longer consultations (attracting larger rebates) than do general practitioners.

Lesser trained personnel are likely to make more referrals, to order more tests and to prescribe more medicines (particularly antibiotics) because of their greater uncertainty. Hence, it was recently revealed that 20% of the patients of a walk-in clinic staffed by nurses had to be referred to local GPs and a further 6% to the local emergency department to which it was attached - actually increasing rather than decreasing the workload of that department (even though most of the patients seen by the nurse had only sore throats and colds).[93] The costs per patient in this particular clinic were estimated to be $120-225 - not counting capital depreciation![94] Additional costs per service will be generated if medical practitioners decide to charge a fee for the legally compelled surveillance of their activities (for example, test results and prescribing).

The AMA claims to have won a victory by successfully lobbying for the restriction of the activities of NPs and midwives to particular areas of "expertise" and requiring collaborative arrangements with the medical profession. But as anyone who has observed the political process over time will attest these measures are only temporary inconveniences to allied practitioners on the way to what will ultimately be fully independent taxpayer-funded practice. Governments have always considered the objectives of powerful lobby groups and none are more powerful than the nurses' lobby. As Friedrich Hayek has observed, once governments are permitted to interfere with markets to direct benefits to particular individuals or groups "they cannot deny such concessions to any group on which their support depends."[95] In fact the original projects aimed at introducing NPs to the workforce were conducted at a time when it was believed that there was an *oversupply* of doctors! There is a line of alternative providers wanting to obtain a piece of the action and political reality suggests that they will be successful, at least in part.

It ought to be a fairly uncontroversial generalization to suggest that lesser trained service providers will be less safe. When the initial patient assessment is performed by somebody with limited training then something important may be missed, the wrong referrals made and the practitioner may attempt to manage

93 'Nurse clinic refers 20% of patients to GPs' (21 March 2011) *Australian Doctor* <http://www.australiandoctor.com.au/news/latest-news/nurse-clinic-refers-20--of-patients-to-gps>

94 Mark O'Brien, 'ACT nurse-led walk-in clinic under fire for cost' (22 April 2011) *Medical Observer* 7.

95 Friedrich Hayek, *Law Legislation and Liberty: The Political Order of a Free People* (Chicago University Press, vol. 3, 1979) 151.

conditions that are beyond his or her competence. This problem is not confined to NPs and midwives but extends to all circumstances in which the management of a patient is undertaken by lesser trained personnel. It was recently claimed, for example, that the relaxation of the referral criteria for patients with mental illnesses under the Better Access initiative had resulted in a "burgeoning number of non-clinical psychologists setting up shop with minimal qualifications" and a number of wrong diagnoses and treatments.[96] Even now the concept of "collaboration" threatens to degenerate into a relationship based on adherence to protocols approved by some distant authority. While there are a range of problems associated with clinical guidelines, they also don't solve the kind of educational problem that was disclosed in a study demonstrating flaws in the mathematical understanding of second year nursing students. The average score of these nurses in tests measuring their ability to calculate drug dosages and make some basic mathematical calculations that are required in the workplace was 56%![97] This, say the study's authors, represents an unacceptable risk to practice safety.

Even if a non-medical practitioner is capable of performing some (even many) of the tasks performed by a medical practitioner, how can those patients who could be safely managed by non-medical personnel be reliably identified when even the simplest presentation may herald a life-threatening event? The training issue may be particularly relevant in country areas where the role of the general practitioner survives in its more traditional and most complex form and where extra training is often required before even formally trained medical practitioners can safely practice. However, it has been suggested that not only might NPs substitute for doctors in country practice but they (and even chiropractors) could also do so in emergency departments! And if NPs are permitted to refer directly to other allied health practitioners, which has also been recommended, the standard medical model of care may be by-passed altogether!

Of further concern is that the new breed of providers may be paid by cutting the funds available for traditional medical practice. If nurse led walk-in clinics aim to deal only with simple problems, traditional general practitioners will be left with the more complex, longer consultations and the balance of medical practice (in which the easy consultations often subsidize the complex) will be upset. To these arguments must be added the claim that the wider involvement of NPs will lead

96 David Brill, "Therapists 'diluting' mental health care" (18 March 2011) *Australian Doctor* 5.

97 K.J. Eastwood, M.J. Boyle, B. Williams and R. Fairhall, 'Numeracy Skills of Nursing Students' (November 2011) 31 *Nurse Education Today* 815-818.

to the fragmentation of care so that the left hand will be uncertain what the right hand has done; costs will be duplicated and patients will thus suffer.

Concerns about possible mistakes also mean that nobody is keen to provide insurance for the services of less skilled practitioners. Physicians themselves are becoming increasingly wary of collaborative arrangements that impose upon them an uncertain range of legal risks. Some control over issues of safety can be gained by limiting the types of service that can be provided by less skilled practitioners, by improving training and by ensuring proper supervision. Far less acceptable has been the decision to transfer some of the risks to doctors (and their insurers). It has been suggested that if a doctor receives information regarding a patient with whom he has no professional relationship (for example, a copy of a pathology report for a test ordered by a NP) that he is required to accept some responsibility for the management of that information. This "duty of care" arises because of a faulty code of ethics that considers that doctors have a contract with "the world" – that everybody is their patient – and will apply whether or not a practitioner has a "collaborative" agreement with the relevant NP. The important point is not that the medical practitioner merely accepts some sort of *moral* responsibility, but that he is required to accept *legal* responsibility for a patient who has chosen not to consult him. Furthermore, the limits of that responsibility – what is urgent, what is a reasonable response and so on - will now have to be determined by authority (rather than by the individual as is the case with moral responsibilities). The incorporation of medical ethical codes into legislation has converted what may or may not be moral responsibilities (depending on the moral values of the doctor) into legal responsibilities (depending on the moral values of the State). And our medico-political masters are prepared to extend these responsibilities to the prescribing activities of allied practitioners.

Government directs consumer choice by controlling the circumstances under which choices are made – by providing differential subsidies or excusing some providers from the costs that other providers must bear. In fact, government currently makes relatively few regulatory demands on NPs and has guaranteed to cover the costs of midwife insurance claims greater than $480,000. Similarly, the nurse-operated walk-in centre in Canberra has received $10 million in recurrent funding from the federal government and $2.2 million in capital funding from the ACT government. Of course, medico-politicians can hardly argue about the subsidies provided to their competitors when doctors themselves (thanks again to our short sighted political leaders) have accepted subsidies for their own insurance, infrastructure and other costs.

Government has undertaken to supply a workforce sufficient to provide for the health care needs of a nation yet since health care is a resource with virtually no limits on what could ideally be supplied (and government has other promises to fund) there comes a point at which taxpayers simply cannot fund the ever-increasing demands of the profession. If the same standard of care is to be offered to *everybody* then the standard of care available to *anybody* must be reduced. While we are perpetually disturbed by government's unwillingness to fund certain investigatory tools, procedures and treatments these same considerations apply to the provision of service providers.

Philosophically, whether allied health practitioners might or might not be more costly or less safe is not the critical issue. The point is that it is the proper task of consumers to consider what service provider they wish to attend, what risks they are prepared to take and what they are prepared to pay for a particular service. A genuinely free choice on the part of consumers requires the removal not only of all subsidies but also of all differential regulatory constraints (that must ultimately be reflected in the price). Whether or not nurses or midwives could fund their presence in the medical market place (both within and outside traditional medical practices) without the subsidies provided by government (including the cross-subsidies provided to doctors) cannot be known in the absence of any genuine market test.

B. *Complementary and Alternative Medicine*

Strictly speaking therapies are "complementary" when used in association with standard therapies and "alternative" when patients choose them in place of the standard recommended treatment. Among the most commonly used Complementary and Alternative Medicine (CAM) treatments are herbalism, meditation, chiropractic and dietary therapy. While the prevalence of the use of CAM is uncertain, figures in the region of 50% of the general population are frequently quoted (and these numbers seem to be increasing).[98] In Australia, the market for natural and alternative therapies is estimated to be $3-4 billion annually[99] with practitioners estimated to number in excess of 20,000.[100]

98 E. Ernst, 'Prevalence of use of complementary/alternative medicine: a systematic review' (2000) 78 *Bulletin of the World Health Organisation* 252-257.

99 Terri Foran, 'The natural choice' (1 August 2008) *Australian Doctor* 37 and I.D Coulter and E.M Willis, 'The rise and rise of complementary and alternative medicine: a sociological perspective' (2004) 180 *Medical Journal of Australia* 587-589.

100 Paul Smith, 'Blurring the lines' (15 April 2011) *Australian Doctor* 19.

The shortage of medical practitioners has driven many consumers into the arms of alternative providers. Alternative therapies are popular when the treatments offered by traditional therapists are not effective or when all hope of cure has been abandoned. They come to the fore, in other words, when governments mismanage the workforce and in the treatment of problems like headaches, chronic pain and some cancers. Since physicians cannot guarantee the effectiveness of many of their treatment regimes, and side effects may be severe (particularly with some cancer therapies), patients often prefer to try something "safer" first – even though what they try may be ineffective and quite unsafe. As Greg Melleuish has pointed out, people generally do not have a good understanding of the scientific process and are unable to easily distinguish between bogus and reputable knowledge. Besides, the fact that medical treatments previously certified as beneficial and safe have subsequently been withdrawn because of possible and actual harms has led to a loss of confidence in certifying processes and in the claims of traditional medical practitioners. At a deeper level, suggests Melleuish, is the post-modernist belief that one form of knowledge is as good as any other.[101]

For those who would prefer not to take prescription drugs, lifestyle changes and other non-prescription approaches such as vitamins, herbs, and food supplements present an appealing alternative. CAM therapists are also said to spend more time with their patients – to be more "touchy, feely" – so that the experience is said to be better even if less effective. Not having to obtain and pay for prescriptions is an additional factor in the popularity of these practitioners.

Government is in an interesting position when it comes to the licensing of CAM providers. On the one hand, government would be pleased if the stamp of approval which licensing provides led to an increase in the number of consumers who attended providers who either charged lower fees or whose fees were not subsidized by the taxpayer or whose treatment costs were lower (particularly because they did not involve the use of subsidized prescription medicines). On the other hand, government would not like to see any advance on the current position where only a relatively limited number of the consultations, investigations and treatments of these practitioners are subsidized by the taxpayer (the X-rays of chiropractors, for example).

While the success of an application for licensing as a health profession is said to depend on the potential risk the profession presents to the public, it appears more likely that (in our socialized system) it is the financial implications and the

101 Greg Melleuish, 'Why smart people believe stupid things' (May 2008) *Institute of Public Affairs Review*.

electoral strength of the lobbyists that are more relevant.[102] Indeed, if harm was the critical factor homeopaths might have achieved recognition long ago since one of the virtues of homeopathy is that it is insulated from side effects because many of the preparations are diluted to such an extent that not even a single molecule of the original active ingredient remains! While the problem of delayed treatment because of incorrect diagnosis remains, there is probably more potential for harm from many other CAM treatments (impurities, ineffectiveness, delayed treatment, incorrect diagnoses, drug interactions etcetera). The recognition of these risks has actually been a prominent argument for including rather than excluding CAM from regulatory processes – despite the fact that the licensing by government of traditional practitioners and the approval of particular therapies has done little to ensure safety.

The lobbying activities of CAM providers have not only made licensing and increased taxpayer subsidies more likely but they have also led to the provision of a significant amount of money in grants to investigate the use of complementary and alternative medicines in preventing and managing acute and chronic disease. While these grants may simply be a way of distributing the benefits of office in an electorally efficient way, they also underline the loss of the medical profession's grip on the control of distribution of taxpayer money. Funds are no longer distributed exclusively to those with the "proper" qualifications or only to recognized institutions.

Licensing is also said to depend not only on issues of safety but also on evidence of efficacy. Hence, members of the medical profession often claim that there are not two forms of medicine (conventional and alternative), only medicine that is evidence based and medicine that is not. CAM treatments frequently lack any sound supporting evidence for their use and are often based on concepts that ignore sound scientific principles. Many medical practitioners view the licensing and registration of CAM providers as merely providing official approval for frauds and they have snubbed, derided and often hounded from practice many of those traditional medical practitioners who have engaged in "unapproved" treatments. These attacks on their colleagues have generally been pursued through disciplinary processes that make a medical practitioner liable to suspension or deregistration if he engages in practices that deviate significantly from accepted standards.

102 Paul Smith, 'Naturopaths join push for health professional registration' (1 April 2011) *Australian Doctor* 1.

However, the boundary between "conventional, orthodox" medicine and alternative approaches is not as sharply defined as we may be led to believe. Only about 55% of so-called scientific medicine has been shown to be evidence-based and only about 25-40% by randomized controlled trials.[103] There are many current standard medical treatments that have gained their acceptance through history of use rather than formal clinical testing – and some that have been "proven" useful in the past have now been discarded either because they have been shown to be ineffective or harmful or because better treatments have been discovered. Similarly, many therapies classified as alternative in the past have now been accepted as proven. Once a treatment has been proved effective it crosses over into standard medical practice and loses its status as "alternative". Experimental therapies currently in clinical trials would be viewed as being in the process of crossing over into acceptance as standard treatments.

Similarly, the traditional "alternative" use of plants has provided the source of some of our most valued modern medicines. The blockbusting drug Oseltamivir for treating H1N1 influenza is made from shikimic acid extracted from the fruits of Chinese staranise, and long employed as a herbal treatment for influenza. Aspirin comes from white willow bark and morphine from the opium poppy, both used by the ancient Greeks. Eli Lilly was led by African folklore to the discovery of the Madagascar periwinkle, which was developed into vinblastine and vincristine for the treatment of childhood leukemia and Hodgkin's disease. Similarly, in Australia the traditional plant remedies of the Aboriginals are being studied with a view to the development of modern drugs.[104] Clearly, there is a big difference between saying that we ought not to be guided by something that has been shown to be false and saying that we ought only to believe what has been shown to be true.

If the practice of CAM is going to be considered a marker of charlatanism then the number of identifiable charlatans, including traditional medical charlatans, is bound to increase. University medical faculties are increasingly offering courses in alternative medicine and the Australian College of General Practitioners has opened its own Faculty of Integrative Medicine where GPs are able to learn about "a wide range of mind-body subjects, including spirituality, meditation, hypnosis, environmental medicine and evidence-based herbal medicine".[105] The teaching of

103 MM Suarez-Varela, A Llopis-Gonzalez, J Bell, M Tallon-Guerola et al. 'Evidence based general practice' (*1999*) *15 European Journal of Epidemiology 815-819; D Abeni, C.R. Girardelli, C. Masini et al, 'What proportion of dermatological patients receive evidence-based treatment?' (2001) 137 Arch Dermatol 771-776.*

104 Susan Semple, 'Bush bonanza' (9 May 2008) *Medical Observer* 27-28.

105 Helen Signy, 'RACGP proposes faculty of integrative medicine' (4 July 2008) *Medical Observer.*

these subjects and their practice by some medical practitioners is justified on the basis that these treatments are used to complement rather than substitute traditional therapy (so-called "integrative" medicine). Not unreasonably, CAM providers argue that if alternative therapies have gained enough credibility to be taught to prospective physicians in *their* courses then alternative healthcare practitioners should not be excluded from comparable funding support for *their* training, research projects and service delivery. This is an argument that government appears to have accepted. Various universities and TAFEs now supply masters and bachelors degrees in chiropractics and traditional Chinese medicine and diplomas in naturopathy, reflexology and Ayurvedic medicine.[106]

Unsurprisingly, the taxpayer funding of education, training and Medicare funding for CAM practitioners has generated considerable criticism. Similarly, it has been suggested that since the insurance industry is subsidized by the taxpayer to the tune of $3 billion per year, it is inappropriate for policies to offer cover for treatments such as iridology, reflexology and homeopathy. Clearly, these kinds of questions only arise when taxpayer-derived funds are used to privilege one choice over another. The solution is to stop the subsidies and let people choose both insurance and educational programs from the options generated in genuine markets.

The point is that in a socialized health care delivery system the place occupied by CAM will be decided by the State - in the interests of the mythical "public". While citizens (properly termed "subjects" in this scheme of things) might sometimes suggest that they have a "right" to make choices for themselves about different providers and treatments, these are rights that genuinely exist only in a system based on different philosophical premises that value the individual rather than the collective. In this alternative scheme there are limits on what the State may do and those limits exclude the provision by the State of universal health care and the selective licensing and preferential treatment of particular groups of health care providers. In socialist systems subjects will have their ability to choose CAM compromised by the licensing and subsidizing activities of government. Of course, when government and its advisors devise rules for the collective they can take no account of the specific circumstances of separate individuals. When the State is removed from the equation, no "expert" would have the power to deny an individual access to a particular treatment modality. And the fact of the matter is that even if a properly conducted trial is said to show no net benefit from a particular treatment that does not mean that the treatment benefited no-one in the trial. What

106 Paul Smith 'Blurring the lines' (15 April 2011) *Australian Doctor* 19-23.

consumers really require is in order to determine what therapy they should try is adequate and accurate information about the different therapies that are available.

III. SUMMARY

There is an alternative to the view that government and its agents (which increasingly include the medical profession) should compel us all to abide by the decisions they make on behalf of the collective - that the interests of some, that is, must be sacrificed for the good of others. In this alternative view, there is no such thing as "the public interest" only the interests of separate individuals who are entitled to use their own legitimately gained assets and to make free choices for themselves from the full range of possible choices. In this system the trades and professions are licensed in market processes and the make-up of the workforce would be governed by consumer choice.

A large number of undesirable events have accompanied the belief that it is government's task to protect people from the bad decisions that they may sometimes make. These events are often referred to as "unintended consequences" but they are more accurately inevitable "ignored consequences".

It is inevitable that a licensing process controlled by government must sooner or later result in the exploitation of the process to serve political ends. It ought also to be unsurprising when deliberate attempts to restrict entry to a particular trade or profession raises prices and creates turf wars whilst achieving very little in terms of patient safety. Regulatory controls inhibit innovation and they prevent patients from gaining access to a wider range of treatment options. In the case of health care, the features of a centralized licensing process are predictably exacerbated when they are combined with a universal taxpayer-funded health system. When government finds that it is simply impossible to fund all the health care promises that it has made it necessarily restricts access to care on a collective basis – including access to the best trained providers. That the interests of some are sacrificed to those of the collective or that people are denied the right to make decisions for themselves are integral components of the system itself.

The problem of identifying and excluding the incompetent is something that markets do quite well. People do whatever is necessary to ensure that they do not fail at the things they undertake particularly when there are considerable costs involved in setting oneself up in business. They will, therefore, ensure that their services are of such a quality that consumers will be willing to pay for them and that a prospective employer will want to employ them and continue to do so. In

the absence of the monopoly protection provided by licensing laws, the capacity of consumers to choose alternative providers would also force professionals to pay greater attention to the wishes of consumers and involve them more closely in the decision-making process.

Contracts between consumers and professionals would likely re-emerge as a way to apportion responsibilities and promote self-determination as well as to resolve many of the difficulties in insurance. In fact, as Gross observes, the recognition of contractual arrangements would "provide the basis for encouraging the entry of new professionals into the marketplace, furthering competition by creating a system of alternative approaches to be legally offered even where restrictive licensing laws are in effect".[107]

In free markets, training and accreditation programs (by a variety of university and professional organizations) would arise naturally and compete for customers on the basis of how well their recommendations predicted quality. The post graduate training that doctors received would be governed by what patients were prepared to pay (rather than by the item numbers and rebates negotiated with government), there would be a range of service providers available with different skills and competencies attracting different fees. Due to all these factors the *overall* standard of care would be higher. Professional discipline would continue to be exercised through the failure to receive referrals or hospital appointments. The incompetent professional would lose respect, reputation and business and would be liable to legal action for negligent service provision.

The unwillingness to question the sacred principles that underlie a system that is clearly not working have resulted in reforms that have concentrated on the surreptitious introduction of quasi-market principles at various points in the system – permitting, for example, the "market" entry of some providers but not others. However, nothing less than a full return to genuine markets in the delivery of health care will solve the problems that beset the current system.

107 Stanley Gross, *Of Foxes and Hen Houses* (Greenwood Press, 1984) 179.