Regulating health

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Would regulation of alternative health programs be good for consumers?

This article reviews arguments about registration of occupational health groups in Australia. The terms registration and regulation are used interchangeably. Registration such as that provided under the *Medical Practitioners Act 1938* (NSW) is only one form of regulation or control. Another form of regulation is occupational licensing. The most convincing economic argument favouring registration is that it ought to be extended to certain health groups to correct the problem of health users being deprived of sufficient information on which to make a proper choice of health care. The usual arguments made against registration – that it results in standardisation of care and the legitimation of the health profession concerned – lack substance. The most convincing argument in favour of registration is registration helps protect the essential paradigm of a health group from colonisation by traditional medicine.

The hierarchy of health knowledge

Different health traditions have always existed. In one sense there is nothing new about the re-emergence of some medical views, and the creation or importation of new views. Medical history is a struggle between different popular views of knowledge and the emergence of the professions to a predominant position.

Roth's analogy between religious movements and alternative health groups is instructive here because as a 'sect' experiences success and acceptance it changes and compromises the closer it moves towards acceptance.[1] This process happened with chiropractic (see below).

The medical profession has achieved a pre-eminent cultural position and has constructed the position of alternative medicine accordingly. Based on its own scientific and supportive legal paradigm, modern medicine has structured the relationships of all health professionals. Despite seeming autonomy of other groups, doctors are regarded as sitting at the top of the pyramid of control through their allegiance and support from traditional science together with their political legitimation. This is done by doctors sitting on the Registration Boards of other health groups. The reason for this dominance has less to do with the fact that as knowledge grows more specialisation is necessary, but more to do with the medical profession's ability to establish political support to help endorse its place in the health market.

As the medical profession was the first to be registered it achieved a monopoly over the entire medical field. Doctors used several strategies which have been called subordination, limitation and exclusion. Subordination is where the character and activities of an occupation are delegated by doctors so there is little scope for independent autonomy and self-regulation as in nursing or midwifery. Occupational limitation is seen in the areas of dentistry, optometry and pharmacy, where treatment is restricted to a specific part of the body and specific areas of operating.

Doctors have *excluded* other professions, such as acupuncture, based on alternative or competing medical practices from receiving legitimation. Alternatively, doctors have dealt with the threat of market competition and

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rival professional status by absorbing an alternative practice, such as homeopathy, into their own system.[2]

In New South Wales ten health occupations have been registered under the same type of registration granted to the medical profession. This system provides for control of the profession's educational entry standards, monopoly of practice and self-discipline through peer review.

Well organised political activism by organised health groups has ensured their progression towards the fruits of professionalisation. Doctors do not sit on the registration boards of some groups. While respective health groups attempt to obtain their own autonomy and distinctiveness they also try to *emulate* the obvious success of the medical profession by tertiary implementation of their courses, more scientific legitimation and a general copying of the 'legitimation' rituals of the medical profession.

Chiropractors are an illustration of this. Registration was eventually obtained, after much medical opposition, at the price of narrowing the scope of chiropractic practice. In New South Wales, registration of chiropractic was granted on the basis that one doctor sits on the Chiropractor's Registration Board, and chiropractors should not be allowed to call themselves 'doctor'. Chiropractors have no visiting rights in hospitals and despite the positive recommendation of the Medicare Review Committee, treatments do not earn a Medicare refund. As a condition of a degree of acceptance, chiropractors have embraced a partial 'medicalisation' as their educational process becomes more like allopathic medicine. Some chiropractors advocate that chiropractic is at the 'cross roads' as they argue it must embrace science and relinquish its evangelist past.

What is of interest here is how different 'truths' compete (even within one health group) for cultural dominance or a niche in the market place. All too frequently the views of one group are misunderstood or misrepresented by another group as they try to 'translate' the 'claims' of the other into their own terms. This should not surprise us as:

> understanding takes place almost exclusively *within* one's own culture. What is alien is supposedly *understood* once it is *translated* into familiar categories. When 'out there' . . . [researchers] seize whatever they can, transfer it into their own culture and insert it into their own contexts, carefully caulking the cracks.
>
> Understanding is not comprehending. To understand means simply to incorporate the werewolf into the intellectual menagerie provided by our culture. This menagerie guarantees objectivity. Objectivity means control. The werewolf is located, measured, palpated, seen. However, what is kept in that zoo is no longer the werewolf. The werewolf remains in the wilderness, and the demons flee from analytic perusal.[3]

A similar phenomenon frequently happens when western medicine criticises alternative or indigenous medical systems. The above examples demonstrate that what is unique and of value within alternative medicine is depreciated by a false accommodation or explanation in terms of science as part of the process of alternative practitioners obtaining professional status.

State regulation of health practitioners

Medical doctors were the first health group to obtain registered status in New South Wales in the early 19th century.

Initially the movement for registration for doctors was opposed, as it was seen as an attempt to obtain a monopoly of the medical market. It was argued citizens should not be deprived of the services of a chemist, or unorthodox practitioner.

Given the opposition, what accounts for the passing of the Medical Registration Acts? Lewis and MacLeod explain medical registration as resulting from the greater prestige from scientific medicine based on its association with the advancements of science.[4]

Since the registration of the medical profession, there has been a series of reports considering the question of registration of ten other health groups. Subsequent groups have been registered following a variety of rationales, including keeping out charlatans, certifying groups endorsed by Medicare or enabling the public to recognise properly qualified people. Recently the justification was made that 'a health service provider group should be registered where there is a potential to cause serious physical harm or death'. In general, there has been conformity among Australian States and Territories as to the particular health groups registered, with the exception of the Northern Territory enacting omnibus legislation.[5]

Northern Territory legislation is an important instance for my thesis that variety or plurality of medicine can be achieved and preserved together with a measure of control of practice.

In recent years there has been a flurry of reports with heightening pressure for registration particularly for acupuncture and naturopathy. A 1990 NSW Discussion Paper says approaches for registration have been received from occupational therapists, acupuncturists, radiographers, orthoptists and prosthetists, orthotists, speech therapists, dietitians, natural therapists, and social workers. At least in the short term, with the growth of mutual recognition legislation, it is unlikely any one State would register another health occupational group. All States would have to agree to such legislation.

Regulation and the public interest

It is said the basic principle under which to consider the registration of professional groups is subsumed by the question of what is the 'public interest'. It is widely acknowledged that registration is not given to support or reinforce a professional occupation or status:

> The granting of self-government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power is not conferred to give or *reinforce a professional or occupation status.* The relevant question is not, 'do the practitioners of this occupation desire the power of self-government?', but 'is self-government necessary for the protection of the public?' No right of self-government should be claimed merely because the term 'profession' has been attached to the occupation.[6]

Thus the term 'public interest' has come to reflect a concern for a just balance between all relevant sectional interests of the public. This includes the interests of professionals who want a return on their human capital and the interests of the consumers who seek a full array of professional services at affordable prices.

The economic rationales for regulation

A fundamental argument for regulation is that it is needed to repair the market failure caused by a consumer's lack of information about the quality and competency of a professional health service. In the health market, information is asymmetrically distributed as sellers know far more about their product than buyers.

Freely available information is especially important for health services as a consumer of a health service is not in the same position as a consumer of a typical consumer product. It is difficult for consumers after using a health service to decide whether they would have been better off with treatment else-

where. Search costs for alternative adequate information may be prohibitive. Patients may not seek information even if it existed. Finally the consumer in health matters is not necessarily the consumer but the doctor who frequently acts as an 'agent' for the consumer.

The implication drawn from consumer ignorance is that regulation by registration will assist and guarantee a quality product and consequent consumer protection.

There have been two main criticisms of this argument: first, consumers of health services are regarded as well educated and capable of making sophisticated choices. It is argued in an age when medical science cannot cure many diseases, consumers are increasingly able to take responsibility for their own health.

Second, a better informed public does not necessarily come about by registration. Other factors such as public education may improve public knowledge about health choices. Thus the impact of regulation on public protection from ignorance is not as certain as advocates of regulation may claim.

I consider the view that regulation should protect customers from ignorance remains intact despite these criticisms.

An assessment of the economic theory on professional regulation

One strand of recent economic opinion now argues that government intervention is excessive and should be reduced as we have free markets in other commodities that are just as basic as health, and there is no compelling case to single out health. Moreover, efficiency and equity are hindered by excessive regulation since producers are exempted from competitive pressures. The current opinion is that deregulation best suits the public interest rather than an extension of regulation and further registration of currently unregistered groups.

There is a lack of empirical studies to decisively show that regulation has economic effects that are not in the public interest. Health economics has experienced difficulties in developing techniques for the assessment of the effects of regulation of health care. Two techniques: the 'human capital' approach, and the 'willingness to pay' approach have proved problematic. A more sophisticated evaluation technique which holds in quality of life factors has proved of greater value.

Not only has the basis of findings on the effectiveness of regulation been questioned, but also emerging studies are confusing and lead to no clear cut conclusion. In Australia there is a lack of 'cost benefit analysis' studies on the effect of regulation. A recent study on the 'cost effectiveness' model concluded that the cost of continuing registration of chiropractors and osteopaths would be minimal.[7]

A general scepticism has developed towards the free market approach in health care. The United States cost crisis and some recent theoretical developments have led many health economists to doubt the efficiency of the market solution. Market-based systems have been seen as more effective if they exist alongside parallel regulatory frameworks.

There are other *non-economic* considerations as to whether 'alternative' health groups should be registered:

- are existing unregistered groups dangerous; and
- are the views underpinning these groups of sufficient importance?

Legal, economic and sociological theories

New political economic theories, frequently underpinned by 'law and economics', have shown some of the undesirable features of regulation such as increased costs, standardisation of health care and a shortage of practitioners.[8] By contrast with the welfare theory this view cynically sees the purposes or the results of regulation as promoting professional interests. This critique was paralleled by sociological studies which emphasise the private and class interests the professional ideal serves.

The purpose of professional regulation in the health field was claimed to be the protection of public health and safety. Regulation attempted to do this by the elimination of charlatans, incompetents and unethical practitioners.

Many American scholars (particularly those inspired by a 'law and economics' analysis) argued that regulation was detrimental as it did not lead to an improvement of services. Rather it had led to an increase in costs and had restricted experimentation and innovation.

The major strands of this sort of criticism were that regulation led to a standardisation of medical service and legitimised an interest group with the commensurate dilution of the service ideal in favour of self interest rather than 'public interest'.

Standardisation

In the United States there is an argument in favour of regulation that it has the effect in the health professions of drawing lines between specialists, enabling one group to claim it is the holder of a controlled, standardised health profession. This arguably enhances consumer protection as consumers are protected against incompetent practitioners or products.

The rationale underlying the 'standardisation' thesis is that health groups create fictions to reinforce their differences in order to increase their market position. The problem with the 'standardisation' claim is it retards innovation or experimentation with new techniques and hinders educational development. The very act of defining the limits of the scope of practice and qualifications necessarily restrains innovation.

Without a competitive spur, a monopolist is not forced to tap all sections of the market and the resultant lack of competition leads to a lack of product variation and a lessening of consumer satisfaction.

Havighurst and King claim in the United States the medical professions system of private certifying of specialists is not a measure to increase choice but is a crucial tactic to standardise medical care and to limit the flow of information concerning the differences among practitioners.[9] Certifying specialists is thus seen as a way of fostering both actual and apparent homogeneity.

It is arguable health groups once registered do not necessarily project a standard product to reinforce their market position. This is so for two reasons.

First, professions are loose amalgamations of segments pursuing different objectives under a single name but operating in a wide range of ways, Different groups within a profession are always competing for control. It follows any one particular alternative health group comprises a wide variety of techniques and philosophies towards health care.

Second, differences between natural therapies and medicine are now fading and their diagnostic techniques and treatment are converging. Many alternative therapists re-train in several modalities. Frequently practitioners (both medical and alternative) combine modern and traditional into one syncretised health care system.

The legitimation argument

It is the policy of groups to pursue registration as part of their professional strategy of obtaining increased status and market

position by admission of their courses to tertiary institutions, by medical insurance refunds, etc. Registration is important to health groups as it creates a franchise in a specific area of expertise assisted by control over entry requirements to maintain a monopoly in the interests of maintaining standards. Registration supports exclusive privileges.

The concern that registration ends up serving the interests of the regulated is well reflected in the sociological literature. One approach called 'capture theory', suggests that while in fact the role of regulation is to protect the public interest, the actual purpose is subverted by the influence of the regulated industries or the regulators, so the regulators come, probably unwittingly, to serve the interests of the industry rather than the public.

Some early work on the sociology of the professions described their ideal of public service. The liberal professions were seen to be representing, in the tradition of Durkheim, the institutionalisation of altruistic values as they were committed to personal service and community welfare.

This approach has been criticised for assuming and adopting the ideal image offered by the profession itself. For instance, the Marxist approach to the professions denied its normative functions and questioned its ethical character by stressing its role of power and market control over knowledge.

The main problem with this criticism is that hidden intentions or 'purpose served' interpretations are thrust forward as the *real* explanation of seeking registration. In this analysis the ideal of professional service has often been cynically ignored or downplayed. Recently Halliday has argued that the 'corrective pendulum' against 'benign functionism' has swung too far. He argues it is time to move beyond:

> unmasking functionalism and monopoly power to realise that there has always been a tension between self-interest and civility, private satisfaction and public service, autonomy and accountability, prestige wealth and a helping function.[10]

The major argument against professional regulation in the US is that regulation has led to a standardisation of services and a consequent loss of consumer choice and has legitimised or reinforced professional privileges.

Richardson, after reviewing this literature, argues that both of these approaches have been misused:

> The comparison of an imperfect market with an omnipotent and benign government and the comparison of a stumbling and purely self-interested regulatory body with a fantasised competitive environment are equally invalid.

He argues the:

> case for intervention [in the health arena] depends on quantitative relationships between means and objectives, and upon the social judgments which determine the relative importance of different objectives.[11]

Should alternative practitioners not be registered because registration merely gives them legitimation with no apparent public benefit? Registration gives obvious professional advantage to a health group. The possible advantages to the public of registration should be mentioned. These include at least to some extent an upgrading of services, higher entry standards, peer review and, at best, a proper complaints procedure.

Studies of the battles of several groups to get registration, have shown that frequently the registration process is a negotiated settlement. Health groups give up claims for a wider health jurisdiction in favour of the perceived advantages of registration. At least this is their claim when they seek registration.

The 'theory of public interest' normally requires a balancing of the various interests (or parties) involved. Many consider that the private interests of a group should not be taken into account when considering registration. This contrasts with a better view in an American report that value should be given to the interest a practitioner may have in his professional career and livelihood.[12]

Protection of the public against harmful or fraudulent practitioners

There is little serious public concern about harmful or fraudulent alternative health practitioners. Apart from a few sensational cases blown up by the press there are few complaints made against alternative therapists. Certainly, for what it is worth, there are few complaints to the NSW Department of Health Complaints Unit (soon to be replaced by the Health Care Complaints Commission). One reason for this may be that health complaints bodies do not have jurisdiction over such complaints and can only refer the complaint to the relevant therapies certifying board (if any).

"But you can't sue me for malpractice. I'm not a doctor."

The low complaint level may be because alternative medicine is based more on non-intervention into the body than traditional medicine. It is conceded harm can ensue if such treatment delays 'proper' medical treatment. This view was reinforced by the Health Department evidence before the Victorian Parliament's Social Development Committee which indicated in its 1979 Report that there was 'very little concern over harm caused by alternative practitioners at the present time'. The Committee therefore considered there was no case for registration based on public protection. Because of the growing popularity of alternative medicine, the Committee's report considered some form of regulation 'short of registration was required to protect consumers', and it recommended the complaint procedure be widened to include complaints against alternative practitioners.

The view that alternative medical practitioners cause no harm is not really convincing. If the mechanisms within registered health groups (which help control malpractice suits and establish internal disciplinary and professional ethics) are not securing sufficient standards, what must the position be for existing alternative practitioners with their disparate treatments and less organised structure? I suspect there is an unrecognised standards problem with alternative medicine. The view that alternative medicine causes no harm is uncritical, and this issue

is undeveloped in the literature. It is convenient for some health groups to argue that particular practices are harmful so that registration prospects can be enhanced.

In 1981, the Standing Committee of Australian Health Ministers concluded:

> that a health service provider group should be registered where there is potential to cause serious physical harm, or death, to a recipient of the services or in respect of which significant government payments are made. [media release]

The existing argument that non-registration is dangerous and the public ought to be protected by registration has proved to be a compelling argument by lobby groups seeking registration. Frequently this involves a turf battle over what is considered to be dangerous, with competing practitioners concerned about the advancement of their own interests.

The 'dangerous situation equals a need for registration' argument has been frequently wielded in recent years in Australia. This weapon has secured registration more effectively than 'truth claims' about the scientific effectiveness or proof of a health group's treatment effectiveness.

For instance, in 1977 the Commonwealth Webb Committee was set up to investigate whether or not chiropractic should be registered. It found no compelling research evidence of its effectiveness; nevertheless it recommended registration. While the Committee would have preferred to restrict spinal manipulation to doctors, it acknowledged chiropractors were well entrenched and, since spinal manipulation could be dangerous and untrained manipulators could not be banned, the next best thing was to regulate them and improve them through education.

A similar dynamic process towards registration seems to be developing in the case of acupuncture. After a series of negative reports doubting the validity of acupuncture and recommending against registration, suddenly in 1991 the NHMRC convened a new working group on acupuncture education which resulted in a press release dated 9 November 1990 which read:

> in the interests of providing a high standard of safe acupuncture practice, the NHMRC has recommended the provision of undergraduate acupuncture education in suitably staffed and equipped universities in the tertiary sector.

The working party made this recommendation:

> In view of the potential dangers inherent in acupuncture this working party recommends, in the interests of optimal public safety that the registration of acupuncture practitioners be expedited.[13]

Having criticised acupuncture for being unscientific and dangerous, it seems it can be made acceptable by tertiary education and regulation. In other words, 'what previously was a barrier now becomes a route to security'.

From recent cases in which health groups have obtained registration, it is possible to conclude that what seems important as a basis for registration is not scientific evidence of effectiveness but 'clinical legitimacy'. By 'clinical legitimacy' is meant:

> in order to survive and flourish over time any health occupation must continue to be patronised by clients. In other words, it must be regimented on the job, in the day to day routine performance of its work in the practical solving and alleviation of the health problems of its patients.[14]

This test was accepted by the Medicare Benefits Review Committee in 1986 as an evaluative criteria for Medicare rebates.

The struggle for 'turf' between the various health professions, together with their political lobbying and truth claims, must be critically appreciated. The best test for registration is clinical legitimacy. The claim that registration should be procured to protect the public from 'harm' must be critically appraised as it is all too frequently a red herring.

Recommendations

Regulatory options

Two models for registration demand serious consideration. One is professional registration in the role of the medical model as under the *Medical Practitioners Act 1938* (NSW). This would allow for regulation of the profession which, in essence, allows monopoly of practice, self discipline through peer review boards and the control of educational entry requirements.

The other model is provided by the example of occupational licensing as extended to cover travel agents, motor vehicle dealers and general insurers. This control was introduced after consistent complaints by consumers. Legislation controlling these activities consists typically of stringent controls and a registration board consisting of members from a variety of associated backgrounds but not exclusively from the industry concerned.

For reasons of completeness, the strategy of direct government regulation by a Minister or department should be noted. This option provides maximum accountability to the public but is unsatisfactory as it gives no autonomy or independence to a profession and makes unrealistic expectations on governmental expertise.

A final possible form of 'regulation' is deregulation. This is regulation nonetheless because it substitutes regulation with market regulation, the theory being that market conditions themselves will ensure the best situation for the consumer. This approach, is similar to the standard flawed arguments of the law and economics critique of health regulation.

A variety of strategies are available to legislative assemblies to control health professionals. Although in theory the choice is large, the effective range of choice is more circumscribed. Registration in the form adopted in the registration of doctors, chiropractors, etc. can help structure and develop the services available. Registration in this form is more open to democratic control than the 'market' on elite professional credentialing or licensing mechanisms for structuring individual choice. The form that legal recognition takes can help structure the outcome.

As law is capable of altering attitudes and redefining relationships, registration should be extended to suitable alternative modalities in order to give a choice of health treatment to consumers. Registration will allow the benefits of title protection, raising of entry requirements, and the proper processing of complaints.

To deal with complaints, each health group should have a sub-committee. This committee should consist of two board members and one consumer representative. Decisions of this committee should be passed to the full board for ratification. As a further measure I recommend that a Health Ombudsman be created for all newly registered groups to serve as an appeal mechanism or to initiate proceedings. I am not in favour of medical doctors sitting on such boards as has frequently happened in the past. This would result in the new therapies losing or having their distinctive premises 'watered-down' as they were increasingly pressurised to justify their work in the light of the dominant scientific paradigm.

New South Wales has recently passed legislation to create a Health Care Complaints Commission which will have a dual

conciliation and disciplinary role. The Commission has yet to commence operating but it may also serve as a model.

Generally there has been a move towards the placement of lay members on registration boards to protect the wider public interest and to provide a balanced perspective. The claim is frequently made that such members merely become captives of the interests of the dominant position on the board or defend those with expertise.

It may well happen that lay members simply defer to the 'modality-expert' on a particular board. I see this as a risk worth taking given the value of lay participation.

The criteria for registering a particular health group

The scope of practice of a health group should be clearly defined. While different approaches are possible within one health group, generally a group should be united by one tenet or approach. Furthermore, to obtain registration, clinical legitimacy should be established together with a high degree of consensus about appropriate skills and measures of competence.

The difficulty is to separate groups such as acupuncture and naturopathy from others which may be less genuine such as pyramid treatment, gem treatment or the Bulgarian School of Suggestology. The problem is compounded in that charlatans may exploit the holistic label to gain credibility. It is up to the group concerned, which has a vested interest in any official recognition, to prove the validity of its professional skill by any criteria or paradigm it seeks to put forward. Measures or standards of incompetence must be clearly ascertainable. Such a requirement would act as a litmus test to put the onus on a group to establish its own professional organisation and professional fitness.

As regards the 'professionalism' of a health group it should be a requirement for each group to demonstrate there is some degree of professional organisation and coherence supporting the modality. While complete agreement could not be expected in any group or class of persons, strong factional divisions would detract from the professional standards and ethics of a health group. It is not the role of a government department to use its resources to police the turf between various factions of a group to establish which group is the majority or which subgroup has the most effective treatment.

Conclusion

On balance, the most persuasive and only credible economic argument is that regulation protects the customer against asymmetry of information. I do not believe the arguments about standardisation of health care or that registration legitimises a group are sufficiently strong to hinder registration.

Further, the claim made on behalf of a group seeking registration that the public should be protected against the possible effects of non-registered activities or practices, must be weighed against the possible clinical legitimacy test. Legislators should thus be cautious of claims of harm by practitioners of a group seeking registration which is relatively uncommon or is in reality a claim for a professional monopoly of an occupational territory.

The strongest argument for extending registration to other groups is to encourage a plurality of health services and to prevent alternative groups from taking over the perspective of traditional medicine to the detriment of their own paradigm.

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