



Health Insurance Amendment (New Zealand Overseas Trained Doctors) Bill 2009

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Social Policy Section

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Health Insurance Amendment (New Zealand Overseas Trained Doctors) Bill 2009

Date introduced: 21 October 2009

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Sections 1 to 3 will commence on Royal Assent. Schedule 1 will commence on 1 April 2010 or on Royal Assent, whichever is the later date.

Links: The [relevant links](#) to the Bill, Explanatory Memorandum and second reading speech can be accessed via BillsNet, which is at <http://www.aph.gov.au/bills/>. When Bills have been passed they can be found at ComLaw, which is at <http://www.comlaw.gov.au/>.

Purpose

The purpose of the Health Insurance Amendment (New Zealand Overseas Trained Doctors) Bill 2009 (the Bill) is to amend the *Health Insurance Act 1973* (the Act) to remove:

- restrictions which apply to New Zealand permanent resident and citizen medical practitioners who have obtained their primary medical education at an accredited medical school in Australia or New Zealand
- the specification in the Act that the period of ten years during which overseas trained doctors are restricted from accessing Medicare benefits must commence from the time the doctors become permanent Australians, even if they became medical practitioners prior to gaining that residency status.

The Bill also introduces a time period in which medical practitioners can appeal against the refusal to grant a section 19AB exemption, or a decision to impose conditions in connection with an exemption which has been granted.

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Committee consideration

The Senate Standing Committee for the Scrutiny of Bills had no comment to make on this Bill.¹ The Bill has not been referred to a committee for inquiry and report by the Senate Selection of Bills Committee.

Background

Medical practitioner shortages

In the mid 1990s, the view that Australia produced sufficient medical practitioners to meet the health needs of the population, which had dominated policy thinking for some years, began to be questioned as doctor shortages became increasingly obvious in rural and remote areas. Initially, because general practitioners and specialists were concentrated in major urban areas, it was considered that rather than there being actual shortages in the medical workforce, there was a mal distribution between the bush and metropolitan areas. This thinking prompted the Howard Government, following its election in 1996, to introduce legislation and initiatives intended to address medical workforce mal distribution.

As there is a constitutional restraint on governments which prevents them from introducing legislation to ‘conscript’ the services of Australian medical practitioners to work in certain areas, doctors who had obtained their primary medical qualifications overseas became the focus of the Government’s strategy.² Amendments to the Act were introduced which obliged these doctors to agree to practice in rural and remote areas where medical workforce shortages had been identified, if they wished to access Medicare benefits for the services they provided.

In addition to the restrictions on overseas trained doctors, the Government limited the granting of new Medicare provider numbers to people who had achieved minimum proficiency qualifications, (that is, specialist medical qualifications), including specialist general practitioner qualifications.

These restrictions have become known as the provider number restrictions,

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1. Senate Standing Committee for the Scrutiny of Bills, *Alert digest*, no. 13, 28 October 2009.
 2. The Constitution section 51(xxiiiA): Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to: the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.

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Provider number restrictions

Specialist qualification restriction

The minimum proficiency requirements for new medical practitioners are imposed under section 19AA of the Act. Under this section, medical doctors who were first recognised as medical practitioners on or after 1 November 1996 are unable to claim Medicare benefits, unless they satisfy certain conditions. These are that they are recognised general practitioners, specialists or consultant physicians or they are undertaking approved, authorised placements.³

The practice location restriction

Section 19AB of the Act imposes restrictions on medical practitioners who did not obtain their primary medical qualifications in Australia. These medical practitioners are known as overseas trained doctors or International Medical Graduates.

Under the 1996 legislation, permanent resident overseas trained doctors were not subject to the restrictions if, before 1 January 1997, they were registered with an Australian Medical Board or eligible to have their qualifications assessed by a Board. However, those who did not meet this requirement were not eligible to claim Medicare for a certain period. These restrictions are commonly referred to as the ten year moratorium.

Temporary resident overseas trained doctors are subject to restrictions under section 19AB of the Act for an indefinite period.

Exemptions to the requirements under section 19AB can be granted to overseas trained doctors if they agree to work in areas where there have been medical workforce shortages identified. These areas are known as Districts of Workforce Shortage (DWS). DWS are areas in which the community is considered to have less access to medical services than that experienced by the population in general. This can be because of the remote nature of certain communities or because of the lack of services available to those communities, or a combination of these two factors.

Importance of section 19AB as a workforce strategy

In her second reading speech on this Bill, Minister Roxon iterated the view that provider number restrictions under section 19AB have had a significant impact on medical

3. Recognised general practitioners are either vocationally registered general practitioners or persons who hold Fellowship of the Royal Australian College of General Practitioners (that is, a postgraduate qualification). Approved placements are authorised by the Royal Australian College of General Practitioners, General Practice Education and Training Limited, one of the specialist colleges. They can also be approved under a program specified under section 3GA of the Act.

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workforce outcomes for rural and remote areas of Australia.⁴ The previous Government also maintained that this had been the case.⁵ Other health organisations, particularly those who deal with rural and remote health issues, agree. Organisations like the National Rural Health Alliance praise the valuable contribution overseas trained doctors have made in rural and remote areas. The Rural Health Workforce Australia (RHWA) argues also that without overseas trained doctors current standards of health care delivery would not be possible.⁶

The Government's 2008 audit of the rural health workforce suggests that section 19AB has indeed made a difference in providing more services to the bush. Moreover, the contribution of overseas trained doctors continues to be fundamental to the delivery of health care in rural and remote areas. According to the audit, in February 2008, the majority of overseas trained doctors who were working in general practice were located in rural and remote areas.⁷

At the same time, an influx of overseas trained doctors into rural and remote DWS as a result of provider number restrictions was not intended as the sole solution to the rural health workforce crisis. The Howard Government put in place various other workforce schemes which were intended to complement the provider number strategy. The present Government has maintained these initiatives. It has also introduced further strategies and commissioned research projects aimed at finding further solutions. One important plan

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4. N Roxon, (Minister for Health and Ageing), Second reading speech: Health Insurance Amendment (New Zealand Overseas Trained Doctors) Bill 2009, House of Representatives, *Debates*, 21 October 2009, pp.3–5.
 5. See for example comments in M Wood 'Hundreds of foreign doctors rushed in', *Sun Herald*, 30 January 2005, viewed 29 October 2009, http://parlinfo.aph.gov.au/parlInfo/download/media/pressclp/ZV1F6/upload_binary/zv1f66.pdf;fileType=application%2Fpdf#search=%22overseas%20trained%20doctors%20overseas%20trained%20doctors%20%20abbott%22
 6. National Rural Health Alliance, *Support for overseas trained doctors*, November 2003, viewed 28 October 2009, http://nrha.ruralhealth.org.au/cms/uploads/publications/2003-3_support_for_otds.pdf and Rural Health Workforce Australia, position paper from Australian Rural Health Workforce Agencies Group, *Recruitment, recognition and retention of overseas trained doctors for the rural and remote medical workforce in Australia*, October 2005, viewed 28 October 2009, http://www.rhwa.org.au/site/index.cfm?module=DOCUMENTS&leca=184¤t_category_code=718
 7. There were 3028 overseas trained doctors working in general practice; 1068 in capital cities and 1437 in rural and remote areas. Department of Health and Ageing (DoHA), *Report on the audit of health workforce in rural and regional Australia*, DoHA, Canberra, April 2008, viewed 22 October 2009, [http://www.health.gov.au/internet/main/publishing.nsf/Content/4F3A981914316A11CA257434008189EC/\\$File/ruraud.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4F3A981914316A11CA257434008189EC/$File/ruraud.pdf)

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adopted by both governments has been to increase the numbers of medical student places to supplement the supply of Australian trained doctors in the future. The effects of this policy will not be felt for several years, however. In addition, there is no certainty that the policy will produce sufficient numbers of graduates who choose to practise in rural and remote areas.⁸ Nevertheless, there are expectations that combined with complementary strategies, such as those to provide more generous incentives for doctors to practise in rural and remote areas, it can assist in making Australia less reliant on the services of overseas trained doctors.⁹

Immigration status of New Zealanders

Under the 1973 Trans-Tasman Travel Arrangement, Australian and New Zealand citizens are entitled to rights to visit, live and work in each other's country without the need to apply for authority to do so. Changes to the *Migration Act 1958* in September 1994, which required all non-citizens lawfully in Australia to hold visas, however, led to the introduction of a special visa to accommodate the Australia–New Zealand relationship. Under the Australian Special Category Visa (SCV), when New Zealand citizens present their passports at immigration, they are considered to have applied for a visa and, subject to health or character considerations, they automatically receive an SCV. The SCV is then recorded electronically.¹⁰

It is not necessary for a New Zealand citizen who holds an SCV to apply for, or be granted permanent residence in Australia. The SCV allows a New Zealand citizen to remain and work in Australia lawfully as long as that person remains a New Zealand citizen.

New Zealand citizens who arrive in Australia on or after 27 February 2001 must apply for, and be granted Australian permanent residence if they wish to access certain social

8. See footnote 1 for explanation.

9. For example, the General Practice Rural Incentives Program provides relocation and retention incentive payments for general practitioners in rural areas. Incentives vary according to remoteness and time spent working in specified areas. Australian Government, 'Part 2: Expense measures', *Budget measures: budget paper no. 2: 2009–10*, Commonwealth of Australia, Canberra, 2009, viewed 28 October 2009, http://www.budget.gov.au/2009-10/content/bp2/html/bp2_expense-16.htm

10. Note: New Zealand citizens who were already in Australia before 1 September 1994, and were still in Australia on that date, automatically became SCV holders on 1 September 1994. Under transitional provisions, these changes do not affect certain New Zealand citizens. For more details see Department of Immigration and Citizenship website Fact Sheet 17, 'New Zealanders in Australia', viewed 26 October 2009, <http://www.immi.gov.au/media/fact-sheets/17nz.htm>

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security payments, obtain Australian citizenship or sponsor their family members for permanent residence.¹¹

New Zealand medical students

Under the current regulations, it can be argued that New Zealand medical students do not enjoy the unique status generally afforded to their fellow citizens. The SCV which allows New Zealand citizens to live and work in Australia for as long as they retain their New Zealand citizenship gives them in effect, permanent resident status without the need to attain permanent residency. On the other hand, New Zealand citizens who have not taken out official permanent residency, and who enrol in Australian medical schools, do not enjoy this status. These New Zealanders are treated as temporary residents. This is because these students are currently captured under the definition in section 19AB—‘former overseas medical student’. At present, this means a person:

- whose primary medical qualification was obtained from a medical school located in Australia and
- who was not a permanent resident or an Australian citizen when he or she first enrolled at a medical school in Australia.

This Bill proposes to remove New Zealand citizens and permanent residents from the category of former overseas medical students. Because of the negligible number of New Zealand medical students studying in Australian medical schools, this is unlikely to have any significant effect on the numbers of doctors whose practice is restricted to DWS.¹²

It should be noted that the proposed changes to the legislation will not exempt New Zealanders from the requirements under section 19AA of the Act. Like all Australian trained doctors, New Zealand graduates of Australian medical schools will be required to gain postgraduate specialist medical qualifications or be in approved placements before they are able to access Medicare.

Extended moratorium

Legislative changes to the Act were made in 2001 to insert a condition that for those doctors registered before 18 October 2001, the ten year moratorium applied from their first recognition as medical practitioners as defined under the Act. However, for those first

11. See ‘New Zealanders in Australia’ fact sheet, op. cit.

12. According to a 2006 study, there were 119 New Zealand medical students in Australian medical schools (or 1.6 per cent of medical students) in 2004. L Hawthorne, G Hawthorne and B Crotty, *The registration and training status of overseas trained doctors in Australia*, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, February 2007, viewed 28 October 2009, [http://www.health.gov.au/internet/main/publishing.nsf/Content/D949ABAA95DCE77FCA2572AD007E1710/\\$File/otdreg.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D949ABAA95DCE77FCA2572AD007E1710/$File/otdreg.pdf)

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registered after 18 October 2001, the restriction applied from the time they were granted permanent residency.

These changes were introduced to close what was thought to be ‘a loophole’ in section 19AB. This loophole may have permitted some overseas trained permanent resident doctors to deem their moratorium to have commenced from their first receipt of an exemption as a temporary resident doctor under the then in existence section 3J(1)(d) of the Act.¹³

In effect, however, the 2001 change meant that some doctors were restricted under the moratorium for periods of more than ten years. This Bill proposes to rectify this situation by removing the requirement that overseas trained doctors who are permanent Australians must have both Australian permanent residency or citizenship and medical registration for the ten year moratorium to commence.

Administrative decisions

This Bill intends to make changes to assist in improving the decision making processes associated with the Act. It is intended that a time limit will be imposed on the period in which a medical practitioner can request review of decisions under section 19AB to refuse the grant of an exemption or to impose conditions on an exemption.

Under the Act, a delegate of the Minister for Health and Ageing decides if an area can be classified as a DWS and if overseas trained medical practitioners can be granted exemptions under section 19AB to allow them to work in the area. The delegate takes into consideration a number of factors including the population’s access to medical services and the remoteness of the area, as noted above. In addition, the delegate also considers a number of other factors, which can change significantly over time, but which can also alter within a short time frame. These include the doctor to population ratio of areas. Doctor population ratio is based on the most recent Medicare billing statistics available, but the grant of even one exemption can mean that an area is considered no longer in medical workforce shortage.¹⁴ Therefore a delegate will also take into consideration various circumstances in geographic areas immediately surrounding practice locations where doctors may seek exemptions. Further, the delegate considers other issues which may

13. K Del Villar, Health Legislation Amendment (Medical Practitioners' Qualifications and Other Measures) Bill 2001, Bills digest, no. 168, 2000–01, Department of the Parliamentary Library, Canberra, viewed 28 October 2009, <http://www.aph.gov.au/library/pubs/bd/2000-01/01BD168.htm>

14. Note: DWS statistics are updated by the Department of Health and Ageing on a quarterly basis to reflect the release of Medicare data. The Department uses what is called a ‘full time equivalent’ measure (FTE), which takes into account the Medicare billing by doctors in an area. This is irrespective of whether doctors in that area are working in a full time or part time capacity. These geographical areas are known as metropolitan or rural Statistical Local Areas.

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indicate the need for more practitioners in an area—a large Indigenous population for example.

The imposition of a time limit on when application for reviews of decisions made by a delegate can be undertaken will make it more likely that the outcomes of review decisions will reflect the specific circumstances under which the original decisions were made.

Position of significant interest groups/press commentary

Restrictions imposed under sections 19AA and 19AB have at times attracted criticism. It was initially claimed, for example, that section 19AA was intended to restrict the number of doctors charging Medicare rather than enhancing the quality of medical services delivered.¹⁵

Criticism of section 19AB restrictions has often tended to focus on how the restrictions have prevented some doctors from working in areas because those areas have not been deemed DWS. Stories of how the legislation (or bureaucratic interpretation of the requirements) has deprived communities of medical services have at times also made for emotive press.¹⁶

In 2007, it was reported that an internal Department of Health and Ageing investigation had found ‘serious flaws’ which indicated that the DWS process needed to be overhauled, particularly in relation to the discretionary aspect of the grant of exemptions under which a delegate decided whether shortages existed.¹⁷ The same report noted the argument that guidelines under section 19AB were in fact discriminatory. This was because they

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15. Kerryn Phelps, President of the New South Wales branch of the Australian Medical Association (AMA) quoted in J Whelan, ‘Overseas GPs plug rural gap’, *Sydney Morning Herald*, 16 February 2000, viewed 26 October 2009, http://parlinfo.parlInfo/download/media/pressclp/E9U06/upload_binary/e9u068.pdf;fileType=application/pdf#search=%22provider%20number%20restrictions%22
 16. See for example the 2001 stories about how the classification of New Norfolk in Tasmania in 2001 prevented the recruitment of permanent resident overseas trained doctors to the area and although a compromise was made to grant exemptions for temporary resident doctors to ease shortages, this measure continued to be regarded by some as unsatisfactory. D Bester, ‘New Norfolk hit by GP crisis’, *The Mercury*, 17 March 2001, viewed 28 October 2009, http://parlinfo.aph.gov.au/parlInfo/download/media/pressclp/SXQ36/upload_binary/sxq364.pdf;fileType=application%2Fpdf#search=%22hummel%22 and J Lovibond, ‘“Quick fix” for shortage of GPs slammed’, *The Mercury*, 11 April 2001, viewed 28 October 2009, http://parlinfo.aph.gov.au/parlInfo/download/media/pressclp/U0Y36/upload_binary/u0y3611.pdf;fileType=application%2Fpdf#search=%22hummel%22
 17. S Parnell, ‘Exemption guidelines for doctors need fixing: report’, *The Weekend Australian*, 17 November 2007, p. 30, viewed 28 October 2009, http://parlinfo.parlInfo/download/media/pressclp/3GYO6/upload_binary/3gyo62.pdf;fileType=application/pdf#search=%22overseas%20trained%20doctors%22

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favoured temporary residents over permanent residents because temporary residents could be ‘more easily restricted to where they work’.¹⁸ Further, the report noted an indirect criticism of section 19AB; that it should not be able to be used as an excuse by which doctors could bypass Australian Medical Council assessment of their qualifications.¹⁹

The issue of ensuring that overseas trained doctors who are granted exemptions to work in rural and remote areas have adequate and appropriate training and support has been the focus of Australian Medical Association (AMA) comment in relation to the operation of section 19AB restrictions.²⁰ At the same time, AMA has consistently been of the opinion that there is ‘no future in a medical workforce policy based on large-scale importation of overseas-trained doctors’.²¹

Indeed, the AMA and the Australian Medical Students Association (AMSA) have not been supportive of the provider number legislation generally. AMSA has been particularly opposed to the application of section 19AB to **any** foreign students trained in Australian medical schools, not just to the New Zealand students who are the subject of the proposed changes in this Bill. AMSA considers it unfair that international students trained at Australian medical schools to Australian standards should be subject to the 19AB ten year moratorium. It believes that the moratorium is counterproductive in this instance as it deters these students from remaining in Australia to complete their training and eventually to practice.²²

The Rural Doctors Association of Australia (RDAA) has supported the ten year moratorium until recently when it concluded that the scheme had failed to address medical

18. Ibid.

19. Ibid.

20. See for example comments from past AMA President Rosanna Capolingua, ‘the most important thing we can do is give IMGs much better support—to enhance their contribution to patient care and to encourage them to stay in Australia for the longer term’. R Capolingua, ‘Overseas trained doctors not the full answer’, Private Hospital, December 2008, viewed 28 October 2009, http://parlinfo.parlInfo/download/library/jrnart/QSNS6/upload_binary/qsns60.pdf;fileType=application/pdf#search=%22overseas%20trained%20doctors%22

21. Australian Medical Association (AMA) past president, Bill Glasson, quoted in M Franklin, ‘Doctor back training push’, *Courier Mail*, 2 May 2005, p. 2, viewed 28 October 2009, http://parlinfo.aph.gov.au/parlInfo/download/media/pressclp/SOWF6/upload_binary/sowf66.pdf;fileType=application/pdf#search=%22overseas%20trained%20doctors%20overseas%20trained%20doctors%20%20abbott%22

22. *AMSA Policy on the 10 Year Medicare Provider Number Restriction for International Students*, Australian Medical Students Association website, n. d., <http://amsa.org.au/docs/moratorium.pdf>

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workforce shortages.²³ A survey undertaken by RDAA prompted its changed policy stance after 60 per cent of doctors surveyed argued that the provider number restrictions had not helped them to recruit and retain doctors.²⁴ As noted above however, recent workforce statistics indicate that this view is contestable.

Prior to the introduction of this Bill, AMA President, Dr Andrew Pesce, wrote to the Health Minister to express the AMA's concerns about anomalies in relation to the ten year moratorium.²⁵ Pesce welcomed the intention to modify the Act as this Bill proposes, but he believed the changes proposed were insufficient.²⁶ In keeping with the AMA's previous views on provider number issues, Pesce added that more needed to be done to address the situation whereby doctors were forced to work for ten years 'with little support in an environment that can be beyond the scope of their training'.²⁷

The AMA correspondence noted however, that the changes could address cases such as that of Mike Belich, an Australian trained doctor who had moved to Australia from New Zealand when he was 14 years old. Belich had been refused a Medicare provider number as a result of the 19AB restrictions. It has been reported that Belich has instigated a 'human rights' case to challenge the moratorium after Medicare had declared he was a foreign graduate. According to *Australian Doctor*, Belich claims he was not informed that a moratorium existed or that he would be subject to its conditions.²⁸

A number of other objections to the provider number legislation surface regularly. A recent case has revived questions about the legitimacy of section 19AB restrictions; that is, do they represent civil conscription for medical practitioners which is prohibited under section 51 of the Constitution. The *Canberra Times* has reported on this issue that the moratorium may indeed be unconstitutional after an Australian National University (ANU) medical student sought legal advice on section 19AB.²⁹ The student, a permanent

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23. S Ryan, 'GPs fight indentured labour', *The Australian*, 27 June 2009, viewed 27 October 2009, <http://www.theaustralian.news.com.au/story/0,25197,25690838-23289,00.html>
 24. P Smith, 'GP launches battle over "force labour" in the bush', *Australian Doctor*, 28 August 2009, p. 4.
 25. A Pesce, Letter to the Minister for Health and Ageing concerning changes to the ten year moratorium, 16 September 2009.
 26. Australian Associated Press, 'Govt "could do more" for foreign doctors, NINEMSM, 22 October 2009, viewed 26 October 2009, <http://news.ninems.com.au/article.aspx?id=878619>
 27. Pesce, letter to the Minister, op. cit.
 28. Smith, 'GP launches battle', op. cit.
 29. R Skotnicki, "GP limits "unconstitutional"", *Canberra Times*, 25 October 2009, p. 6, viewed 26 October 2009, http://parlinfo.parlInfo/download/media/pressclp/IU0V6/upload_binary/iu0v60.pdf;fileType=application/pdf#search=%22overseas%20trained%20doctors%22

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resident subject to the ten year moratorium, was advised that the High Court has indicated the civil conscription prohibition could have a wide area of application and if tested, the provider number restrictions could be found to be illegal. Added to this advice, however, was the warning that a challenge to the legislation ‘would likely be time consuming and costly, and the outcome could prove even worse for the doctors affected’.³⁰

It can be argued that this Bill also resurrects the issue of what actually amounts to civil conscription for medical practitioners. As was claimed recently in *Wong v The Commonwealth*, is it the case that some provisions in the Act compel general practitioners to participate in the Medicare system. While the decision in *Wong* was that the particular provisions tested did not constitute civil conscription, the point was made in this case that the legislative history of section 51 (xxiiiA) ‘treats “civil conscription” as involving some form of compulsion or coercion, in a legal or practical sense to carry out work or services’.³¹ Hence, decisions about whether legislation authorises a form of civil conscription need to be made ‘with close attention to the legislative scheme in question, in particular, to those aspects which are under challenge’.³²

It appears from the decision in *Wong* that the High Court has been of the view that requiring the adherence to regulations which are necessary to the provision of medical services does not constitute civil conscription. Similarly, it appears the Court does not consider even though the Act effectively requires medical practitioners to participate in the Medicare scheme, that this constitutes civil conscription. This is because the Court has ruled that ‘a medical practitioner is free to choose whether to practise’, and ‘where to practise’, regardless of his or her choice to adhere to the conditions imposed under Medicare.³³ Nevertheless, the changes proposed in this Bill may prompt further investigation into provider number regime and encourage others to instigate challenges to its legitimacy.

Financial implications

According to the Explanatory Memorandum, the Bill will have minimal financial impact. It is estimated that an ongoing saving of approximately \$0.2 million will be achieved. These savings are most likely to be in administrative costs.

30. *Ibid.*

31. *Wong v The Commonwealth* (2009) 236 CLR 573, per French and Gummow at 593.

32. *Ibid.*

33. *Wong v The Commonwealth* (2009) 236 CLR 573, per Haynes, Crennan and Kiefel at 639.

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Main provisions

Part 1 of Schedule 1 to the Bill contains proposed amendments to the Act.

Part 2 of Schedule 1 contains application provisions.

Schedule 1 Part 1

New Zealand medical graduates

A number of items in this Bill are intended to deal with what has been labelled an anomaly in the current legislation which has been detrimental to New Zealand citizens or permanent residents who have chosen to study medicine in Australia.

Items 1 and 3 propose to **amend subsections 19AB(1) and (2)** of the Act to replace the term ‘former overseas medical student’ with the term ‘foreign graduate of an accredited medical school’. **Item 6** will insert a definition of the latter term. A foreign graduate of an accredited medical school is to be considered a person:

- whose primary medical qualification was obtained from an accredited medical school and
- at the time he or she first enrolled at the accredited medical school who was not
 - a permanent Australian
 - a New Zealand citizen or
 - a permanent resident of New Zealand.

Item 5 proposes to **insert a definition of accredited medical school** which will mean a medical school that is:

- accredited by the Australian Medical Council and
- located in Australia or New Zealand.

Item 9 proposes to **amend the definition of permanent Australian**. This item will replace the current term ‘permanent resident’ with the term ‘holder of a permanent visa (within the meaning of the *Migration Act 1958*)’.

Item 10 proposes to repeal the current definition of permanent resident.

Commencement of ten year moratorium

The Bill also proposes to address what in some cases has amounted to an unintentionally overly onerous application of the ten year moratorium aspect of the legislation.

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Items 2 and 4 of the Bill propose to **amend subparagraphs 19AB(1)(f)(ii) and 19AB(2)(f)(ii)** in the Act so that the ten year moratorium, which applies to overseas trained doctors who are Australian permanent residents or citizens, applies from the date on which the doctors first become registered as medical practitioners.

Under the current legislation, the moratorium applies from the date on which the persons become permanent Australians. This has meant that in some cases doctors have been subject to the moratorium for periods in excess of ten years. The Explanatory Memorandum cites instances of up to 15 years, and notes that this was not the intention of the original legislation.³⁴ It is expected that a number of overseas trained doctors will no longer be subject to the ten year moratorium as a result of the proposed changes to the legislation.

Review of decisions

Items 11 and 12 insert new subsections 19AC(2A) and (3A) into the Act. Section 19AC provides that persons who have been refused 19AB exemptions or who have had conditions imposed on exemptions may apply for reviews of those decisions by the Minister or the Minister's delegate.

At present, no time limit applies to when reviews of decisions can be sought. **Proposed subsections 19AC(2A) and (3A)** will provide that applications for reviews of decision must be made before a period of 90 days has elapsed beginning on the day after the day that the exemptions were refused or upon which conditions were imposed on exemptions.

Schedule 1 Part 2

This Part provides for application of amendments proposed in the Bill.

Item 13 proposes to define 'exemption condition decision' as a decision under subsection 19AB(4) of the Act which imposes one or more conditions on an exemption. An exemption refusal decision will also be defined—as a refusal to grant an exemption under subsection 19AB(3).

Item 14 proposes that section 19AB as amended under this Bill will apply in relation to services rendered on or after 1 April 2010 or Royal Assent, whichever is the later date.

Items 15 and 16 provide that proposed subsections 19AC(2A) and (3A), inserted under **items 11 and 12**, will apply in relation to exemption refusal decisions and exemption conditions decisions made on or after 1 April 2010 or Royal Assent, whichever is the later date. Where exemption refusal and extension condition decisions are made before the Act

34. Explanatory Memorandum, Health Insurance Amendment (New Zealand Overseas Trained Doctors) Bill 2009, p. 3.

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commences, these proposed provisions will apply as if the period of 90 days referred to in those provisions began at the time of commencement.

Concluding comments

Restrictions on provider numbers for overseas trained medical practitioners were introduced in 1996 in an attempt to address doctor shortages which at first it was thought were confined to rural and remote areas. The restrictions were criticised for a number of reasons and there continues to be some argument that they have not achieved their objectives. However, given the significant numbers of overseas trained medical practitioners currently working in rural and remote areas, the claim that the restrictions have had no discernable impact on the medical workforce in the bush is less than convincing. There are strategies in place to improve the numbers of Australian trained doctors, which it is hoped will further improve the rural medical workforce. These are long term solutions to medical workforce shortages, however, and there can be no guarantee that Australian trained doctors will opt to practice in areas of workforce shortage. It is likely therefore that provider number restrictions on overseas trained doctors will remain in place for some time.

Given that this is the case, the decision to reconsider aspects of the restrictions that have been described as particularly onerous and incongruous appears to be a judicious one. Indeed, it appears particularly unfair that some practitioners have been subject to restrictions for periods of more than ten years when it was not the intention of the original legislation for this to occur. Similarly, it appears contradictory to the special relationship afforded New Zealanders in Australia that those who chose to study medicine at Australian medical schools should be disadvantaged upon graduation. The legislation intends to remedy these anomalies.

The other proposed change in this Bill will set a time limit on the period in which medical practitioners can seek reviews of exemption decisions under section 19AB. Setting such a limit also appears sensible as it is more likely to ensure that the circumstances under which a review process is conducted reflects the circumstances which prompted the original decision.

In effect, changes to the Act for New Zealand citizens and permanent residents will not have a major negative impact on the numbers of doctors who are required to complete a ten year period of service in rural and remote areas of areas of workforce shortage. There may be more impact on doctor numbers from the second change proposed in this Bill, although it is not clear how many practitioners have been subject to an extended moratorium. However, in keeping with the original intent of the provider number legislation, and from the perspective of fairness to doctors who have already made a notable contribution to health in rural and remote areas, it appears justifiable that any effects of the proposed change should be absorbed. Finally, the third change in this legislation is likely to have a positive effect for administrative review process which may be as beneficial to those seeking review of decisions as to those undertaking those reviews.

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