



Health Practitioner Regulation (Consequential Amendments) Bill 2010

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Social Policy Section

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Health Practitioner Regulation (Consequential Amendments) Bill 2010

Date introduced: 24 February 2010

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Sections 1 to 3 on the day the Bill receives Royal Assent; Schedule 1 on a day to be fixed by Proclamation.

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 Practitioner Regulation (Consequential Amendments) Bill is to:

- provide for consequential amendments to Commonwealth legislation to recognise and support implementation of the National Registration and Accreditation Scheme (NRAS) for the Health Professions
- streamline processes involved in the recognition of doctors under the *Health Insurance Act 1973* for the purpose of claiming Medicare.

Background

Basis of policy commitment

In Australia, states and territories are empowered to legislate to register and regulate health professionals. Requirements and conditions of registration for all the professions have therefore varied significantly across jurisdictions. Variations have included:

... the form and content of registration Acts, including, but not limited to, the categories of registration that apply and the terminology used to describe these, the registration application and renewal requirements and processes, the continuing professional development and indemnity insurance requirements, as well as differences in how complaints of unprofessional conduct are investigated and prosecuted and the sanctions that may be imposed. Board funding arrangements (and

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the level of registration fees charged) and the statutory relationships between boards and the responsible ministers and departments also vary widely.¹

Some attempts have been made in the past to simplify the registration and regulation process. The *Mutual Recognition Act 1992* was one such cooperative attempt by the states, territories and the federal governments. This Act allowed individuals registered to practise an occupation in one jurisdiction, to obtain registration to practise an equivalent occupation in another participating jurisdiction.²

Despite this move, and other initiatives, for instance, the establishment of cooperative national arrangements in some professions, which have seen the delegation of certain registration and accreditation functions to national bodies, increasingly there have been calls for greater reform in this area.³ Reasons cited in support of reform have ranged from administrative—reduction of red tape involved in multiple registrations would assist practitioners to move more easily between, and work across jurisdictions—to safety and quality considerations. The issue of safety and quality of care has been the most fundamental motivation for change. This is most likely because inconsistencies which can occur in assessment, registration and renewals of licences for health professional to practice, as well as differences in what constitutes acceptable practice and discipline can, and have had serious consequences for the delivery of safe and effective health care.

Productivity Commission recommendations

In its December 2005 report on Australia's health workforce, the Productivity Commission (the Commission) recommended the establishment of a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training. The Commission saw this move as a means to help deal with workforce shortages and pressures faced by the Australian health

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1. A Carlton, 'National models for regulation of the health professions', *Law in Context*, vol. 23, no. 2, 2006, information based on *Report on mapping of medical registration legislation*, unpublished paper, Centre for Public Health Law, La Trobe University, 2004, viewed 2 March 2010, http://parlinfo/parlInfo/download/library/jrnart/4JXK6/upload_binary/4jxk66.pdf;fileType%3Dapplication%2Fpdf
 2. Clause 20 of the *Mutual Recognition Act 1992*, viewed 2 March 2010, http://www.austlii.edu.au/au/legis/cth/consol_act/mra1992221/s20.html
 3. Carlton, op. cit. Carlton cites the Patel case which is discussed later in this Digest. She also notes three British cases, including the Harold Shipman case, in which a general practitioner was convicted in 2000 of murdering 15 patients. A report into this case was critical of the body responsible for registering the practitioner. For more detail see the BBC website, *Past NHS medical controversies*, viewed 2 March 2010, <http://news.bbc.co.uk/2/hi/programmes/panorama/4852340.stm>

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workforce. It would increase flexibility, responsiveness, sustainability, and mobility, and, in the process also reduce red tape.⁴

COAG agreement

In response to the Commission's recommendations, the Council of Australian Governments (COAG) agreed in 2006 to establish national schemes for registration of health professionals and for the education and training of the health workforce.⁵ In April 2007, COAG announced that one national scheme would be established to encompass registration and accreditation. It intended that the scheme would commence in July 2008 and apply to nine health professions.⁶ COAG was convinced the scheme would deliver 'stronger safety guarantees for the community' as health professionals would be registered 'against the same, high-quality national professional standards'.⁷

The election of a new federal government in November 2007 delayed the implementation timetable for the national scheme. In March 2008 however, health ministers agreed that it would commence operation in July 2010. Under the terms of an intergovernmental agreement for this National Registration and Accreditation Scheme for Health Professionals (NRAS) initially national boards for each of the nine medical professions to be covered were to be established. Each state and territory was required to pass legislation to give effect to the national scheme and to

... use their best endeavours to repeal their existing registration legislation which covers the health professions that are subject to the new national scheme. This will have the effect of abolishing the current state and territory based registration boards for those health professions.⁸

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4. Productivity Commission, *Australia's health workforce*, Canberra, December 2005, viewed 26 February 2010, http://www.pc.gov.au/data/assets/pdf_file/0003/9480/healthworkforce.pdf
 5. Council of Australian Governments (COAG), *Communiqué*, 14 July 2006, viewed 26 February 2010, http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm#health
 6. The professions were: medical practitioners, nurses and midwives, pharmacists, physiotherapists, psychologists, osteopaths, chiropractors, optometrists and dentists (including dental hygienists, dental prosthetists and dental therapists).
 7. COAG, *Communiqué*, 13 April 2007, viewed 26 February 2010, http://www.coag.gov.au/coag_meeting_outcomes/2007-04-13/index.cfm#health
 8. *Intergovernmental Agreement for a national registration and accreditation scheme for the health professions*, 26 March 2008, viewed 26 February 2010, http://www.coag.gov.au/coag_meeting_outcomes/2008-03-26/docs/iga_health_workforce.pdf

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The NRAS was to involve a Ministerial Council, an independent Australian Health Workforce Advisory Council, a national agency with an agency management committee, national profession-specific boards, committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each state and territory.⁹

National bodies set up under the scheme were to have authority to:

- manage the development of registration, practice, competency and accreditation standards and continuing professional development requirements
- approve a list of accredited courses of study that meet the qualifications required for general registration, and
- oversee the assessment of the knowledge and clinical skills of overseas trained practitioners whose basic qualifications are not recognised in the list of approved courses of study and determine their suitability for registration in Australia.¹⁰

Implementation: Queensland legislation

The Queensland Government was given responsibility for the development of the NRAS under an applied laws model. This involved the enactment of a finalised National Law by Queensland. Other states and territories would become ‘participating jurisdictions’, upon enacting their own legislation. The legislation for the other states and territories would include jurisdiction-specific provisions.

Queensland introduced the *Health Practitioner Regulation (Administrative Arrangements) National Law Bill 2008* (Qld) in October 2008. The legislation, which set out the structure and functions of the new scheme, was passed in November 2008.¹¹

Following passage of this first piece of legislation, the Australian Health Ministers’ Advisory Council set up a group to consult on the matters to be included in consequential legislation. In June 2009, the group advised that as a result of consultations undertaken with stakeholders that changes would be made to the original proposals. These were reflected in an exposure draft of the National Law which was released for further public consultation.¹²

9. Ibid.

10. Ibid.

11. The *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008*, viewed 26 February 2010, can be found at:
http://www.austlii.edu.au/au/legis/qld/consol_act/hpranla2008701/

12. The Ministerial Council released the exposure draft of the National Law Bill on 12 June 2009 for a period of consultation. By 30 June a national forum on the draft Bill had been held in Canberra. State and territory meetings were held in every capital. These were attended by more than 950 people and more than 550 submissions were received. The

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The *Health Practitioner Regulation National Law Act 2009* (Qld) (also known as Bill B), which was introduced into the Queensland Parliament following this consultation process, continued administrative arrangements established under the first stage legislation. It also dealt with more substantial elements of the national scheme. These included registration and accreditation arrangements, complaints, conduct, health and performance arrangements, privacy and information sharing arrangements and transitional arrangements.¹³ The Queensland National Law legislation, received Royal Assent on 3 November 2009.¹⁴

New South Wales and Victoria have since passed legislation to adopt the National Law in their jurisdictions.¹⁵ Bills have also been introduced into parliaments in Tasmania, the Australian Capital Territory and the Northern Territory.¹⁶

The National Law operates as a unified set of state and territory laws and, as the Minister for Health and Ageing pointed out in her second reading speech, consequential amendments are required to federal legislation 'to ensure that medical practitioners continue to retain the same Medicare billing eligibility from July 2010' when the NRAS comes into effect.¹⁷

Exposure Draft of the National Law, viewed 26 February 2010, is at:

[http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Exposure%20draft%20of%20Health%20Practitioner%20Regulation%20National%20Law%202009%20\(Bill%20B\).pdf](http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Exposure%20draft%20of%20Health%20Practitioner%20Regulation%20National%20Law%202009%20(Bill%20B).pdf)

13. Explanatory Notes, Health Practitioner Regulation National Law Bill 2009, viewed 26 February 2010, <http://www.legislation.qld.gov.au/Bills/53PDF/2009/HealPraRegNLB09Exp.pdf>
14. The *Health Practitioner Regulation National Law Act 2009* (Qld), viewed 2 March 2010, is at <http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2009/09AC045.pdf>
15. New South Wales passed the *Health Practitioner Regulation Act 2009* (NSW), which commences on 1 July 2010 on 11 November 2009, viewed 26 February 2010, http://www.austlii.edu.au/au/legis/nsw/consol_act/hpra2009317/. The *Health Practitioner Regulation National Law (Victoria) Act 2009*, which also commences 1 July 2010 received Royal Assent on 8 December 2009, viewed 26 February 2010, http://www.austlii.edu.au/au/legis/vic/num_act/hprnla200979o2009563/
16. The Tasmanian legislation, the Health Practitioner Regulation National Law (Tasmania) Bill 2009, is at: http://www.parliament.tas.gov.au/bills/pdf/93_of_2009.pdf. The Australian Capital Territory legislation, the Health Practitioner Regulation National Law (ACT) Bill 2009, is at: http://www.legislation.act.gov.au/b/db_36300/default.asp and the Northern Territory legislation, the Health Practitioner Regulation (National Uniform Legislation) Bill 2009, is at: [http://notes.nt.gov.au/dcm/legislat/Acts.nsf/8951faff2d9faeaa692565610018f15c/e7cf101947c68aa7692576d40003c162/\\$FILE/Bilh024.pdf](http://notes.nt.gov.au/dcm/legislat/Acts.nsf/8951faff2d9faeaa692565610018f15c/e7cf101947c68aa7692576d40003c162/$FILE/Bilh024.pdf)
17. N Roxon (Minister for Health and Ageing), Second reading speech, Health Practitioner Regulation (Consequential Amendments) Bill 2010, House of Representatives, *Debates*, 24

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Committee consideration

This Bill was referred on 25 February 2010 to the Community Affairs Legislation Committee for inquiry and report by 9 May 2010. The reason given for the referral was for the examination of implications for healthcare providers, particularly the reserve powers relating to registration requirements.¹⁸ It is expected that submissions or evidence will be received from:

- the Australian Medical Association (AMA)
- AMA state branches
- the peak bodies for each health discipline.

Details of the inquiry are at

http://www.aph.gov.au/Senate/committee/clac_ctte/health_practitioner_reg/index.htm

Position of significant interest groups/press commentary

In 2008, the Australian Medical Association (AMA), the Committee of Presidents of Medical Colleges (CPMC) and the Royal Australian College of General Practitioners (RACGP) expressed concern that a national registration scheme would not enhance patient safety. The RACGP considered that such a scheme could also amount to interference by government in the setting of professional standards.¹⁹ Further, that there was a danger the scheme could result in the lowering of continuing professional development standards 'to allow some doctors to perform tasks beyond their skill level if the government dictated requirements'.²⁰

The AMA and the CPMC also labelled the model developed by COAG as 'heavily bureaucratized and remote...too centralised and removed from where medicine is

February 2010, viewed 4 March 2010,
http://parlinfo.aph.gov.au/parlInfo/genpdf/chamber/hansardr/2010-02-24/0005/hansard_frag.pdf;fileType=application%2Fpdf

18. These powers are discussed later in this digest. See page 10.
19. S Osborne, 'Registration risks standards: RACGP', *Australian Doctor*, 19 August 08, viewed 1 March 2010,
http://parlinfo.aph.gov.au/parlInfo/download/library/jrnart/S8MR6/upload_binary/s8mr60.pdf;fileType=application/pdf#search=%22library/jrnart/S8MR6%22
20. H Ferguson, 'Regulation threatens CPD standards', *Australian Doctor*, 14 November 2008, viewed 1 March 2010,
<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fjrnart%2FNLN3S6%22>

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practised'.²¹ They proposed instead a model that they claimed allowed 'for more rapid responses to concerns and the exchange of information at the local level to identify local problems and avert potential disasters'.²²

Medical journalist Heather Ferguson noted also:

The AMA and 11 other medical colleges, including the RACGP, were also concerned that national registration could provide a 'vehicle' for other health professionals to take on tasks traditionally performed by doctors without consulting the medical profession. There was no requirement for another health professional board to consult with the medical board prior to any decision to expand their scope of practice or qualifications, they said. 'If the podiatry board independently said their members could operate on ankles ... the government could agree they have adequate training to do that'.²³

In March 2009, as part of the consultation processes involved in setting up the NRAS, the Senate Community Affairs Committee undertook an initial inquiry into scheme.²⁴ The Senate committee noted that a number of changes to the original proposal had already taken place as a result of the work carried out by the National Registration and Accreditation Implementation Project.²⁵ These changes were said to have responded to concerns, such as those raised by the medical profession about maintaining accreditation functions that were independent of government. Other changes to the scheme involved establishing general and specialist registers for professions, separate registers for nurses and midwives, imposing requirements for continuing professional development in relation to annual renewal of registration, and extending the scheme to three other professions from 1 July 2012.²⁶

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21. J Flannery, 'National registration flashpoint', *Australian Medicine*, 7 April 08, viewed 1 March 2010, http://parlinfo.aph.gov.au/parlInfo/download/library/jrnart/S82Q6/upload_binary/s82q62.pdf;fileType=application/pdf#search=%22library/jrnart/S82Q6%22
 22. Ibid.
 23. Ferguson, 'Regulation threatens CPD standards', op. cit.
 24. Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, The Senate, Canberra, August 2009, viewed 1 March 2010, http://www.aph.gov.au/Senate/committee/clac_ctte/registration_accreditation_scheme/report/report.pdf
 25. The National Registration and Accreditation Implementation Project had completed most of its work by 1 January 2010 when all but one of its functions were handed over to the Australian Health Practitioner Regulation Agency (AHPRA) established under *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Qld).
 26. These professions are Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners and medical radiation practitioners.

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The changes made were generally well received by stakeholders. At the same time, some groups remained concerned that there was a potential threat to the independence of the accreditation function undertaken by the various professions. This was inherent in the power to be given under the scheme to the Ministerial Council to issue directions relating to accreditation standards. It was thought that this power contradicted the fundamental objective of the NRAS—to improve patient safety by ensuring health professionals were suitably qualified.²⁷ Similarly, some disquiet was expressed over aspects relating to registration, such as the use of the title specialist. The AMA was concerned for example, that too many people could use the term doctor and that they could be mistakenly considered medical doctors, thereby misleading the public.²⁸

On the other hand, the Australian Osteopathic Association (AOA) pointed out, medical practitioners, dentists and veterinarians are allowed to call themselves doctor if they possess only a Bachelor degree. The AOA sought the use of the title for osteopaths, who have completed a five-year Masters degree and are to be registered under the scheme.²⁹

Discussion about accreditation and registration issues proposed under the NRAS was essentially entwined with what one witness to the Senate committee hearings noted was tension between public safety and quality and workforce supply.³⁰ The underlying fear appeared to be that the necessity of recruiting health professionals to work in difficult-to-fill positions would result in the Ministerial Council bypassing assessment procedures; and bypassing these processes had, in a number of high profile instances, already resulted in considerable harm to patients.

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27. The Committee specifically quoted the Australasian Podiatry Council (APodC) submission to the inquiry, but noted the APodC's view was broadly indicative of the health professions in general. Submission 77a, p. 2, to Community Affairs Legislation Committee Inquiry, op. cit
 28. Joint submission on the Exposure draft of Bill B made by the Australian Medical Association, the Australian Society of Otolaryngology Head & Neck Surgery, the Australian Association of Surgeons, the Australian Orthopaedic Association, the Australian Society of Anaesthetists, the Australian College of Rural and Remote Medicine and the Australian Society of Plastic Surgeons, viewed 2 March 2010, <http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Bill%20B%20Submissions/A/Australian%20Medical%20Association%20Joint%20Submission.pdf>
 29. Australian Osteopathic Association, submission on the Exposure draft of Bill B, viewed 2 March 2010, <http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Bill%20B%20Submissions/A/Australian%20Osteopathic%20Association.pdf>
 30. I Frank, Chief Executive Officer, Australian Medical Council, *Proof Committee Hansard*, 14 July 2009, pp. 21–22, Community Affairs Legislation Committee Inquiry, op. cit.

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The reference to high profile instances of harm most probably included the case of Dr Jayant Patel, who is due to face trial in Brisbane in the first half of 2010.³¹ Patel was an overseas trained doctor who in 2003 was able to gain registration from the Queensland Medical Board and appointment to a Queensland Health surgery post in Bundaberg, despite a questionable medical record. Patel trained in India and worked in the United States for more than 20 years. However, before he sought registration in Australia he had been found guilty of gross negligence in the early 1980s in New York, and again in 2000 in Oregon. He has been accused of manslaughter and causing grievous bodily harm during his time at Bundaberg, as well as committing fraud to obtain his position with Queensland Health.

Recent media coverage has again broached the issue of the role of non professionals in determining standards under the NRAS. It is likely that this issue will continue to be raised in conjunction with any discussion of this legislation. The AMA remains convinced that health ministers will decide training standards for the medical profession and that ministerial deliberations will take place behind closed doors. This will then allow politicians to put workforce or budgetary considerations before safety or quality of care.³² While it has not been clearly stated in the limited media coverage of the issue, there appears to be the implication that the potential for another Patel case may be a possible outcome of allowing unqualified officials to have any role in setting standards for health professionals.

Comment in the March edition of the *Medical Journal of Australia* is also critical of the NRAS. According to former president of the Medical Board of New South Wales, Peter Arnold, there is a hidden agenda associated with the scheme which is about governments combining their powers over new registration authorities (and Medicare) ‘to exercise ham-fisted controls over doctors’.³³ Moreover, Arnold claims, the government’s primary goal is control of doctor numbers, education, registration, standards and the nature and location of medical practice. This view is most likely not shared by the majority of medical practitioners, but it does suggest that some in the medical profession may be concerned about the extent to which the various pieces of legislation under the National Law will influence the practice of medicine and other health professions. These concerns are likely to be included in submissions to the inquiry to which this Bill has been referred.

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31. Wikipedia gives a short summary of the Patel case, viewed 1 March 2010, http://en.wikipedia.org/wiki/Jayant_Patel
 32. T Thompson, ‘Pollies to set medical standards’, *The Courier Mail*, 26 February 2010, p. 15, viewed 2 March 2010, http://parlinfo.parlInfo/download/media/pressclp/060W6/upload_binary/060w60.pdf;fileType=application/pdf#search=%22national%20registration%20and%20accreditation%22
 33. P Arnold, ‘National registration legislative proposals need more work and more time’, *Medical Journal of Australia*, vol. 192, no. 5, March 2010, viewed 3 March 2010, http://www.mja.com.au/public/issues/192_05_010310/letters_010310_fm-1.html

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Since the introduction of this Bill the AMA has made little comment, its main reaction to date has been to express its agreement with the decision of the Medical Board of Australia to maintain the recognition of general practitioners as specialist medical practitioners under the NRAS.³⁴ As it has been a difficult road for general practice to achieve specialist recognition under the current registration and accreditation regime, the lobby group was clearly keen for this not to be undermined.³⁵

The AMA was less pleased that some medical practitioners who are currently recognised as general practitioners may be discriminated against under the NRAS. It had been suggested this may be the case and that only Fellows of the Royal Australian College of General Practitioners (RACGP) and some Fellows of the Australian College of Rural and Remote Medicine (ACRRM) would be considered specialists under the scheme. The AMA wrote to the Medical Board of Australia arguing that limiting the title of specialist general practitioner to those with fellowships would create two classes of general practitioners and would mean in some cases that a highly qualified and experienced practitioner would have the same registration status as a doctor in training.³⁶ The AMA therefore welcomed the Board's decision to allow vocationally registered general practitioners as well as Fellows to use the title specialist general practitioner (**item 27** of the Bill). The AMA saw the decision as a common sense approach to the issue and one which would ensure that thousands of highly qualified general practitioners were not 'shunned and professionally out in the cold'.³⁷

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34. The Medical Board of Australia is one of the national health professional boards established under the *Health Practitioner Regulation (Administrative Arrangements) Act, 2009*. Links to the Board and the other health professional boards established under the Act are at the Australian Health Practitioner Regulation Agency website, viewed 2 March 2010, <http://www.ahpra.gov.au/index.php> and AMA response, AMA, *Medical Board responds to AMA call for recognition of vocationally registered GPs as 'specialist GPs'*, media release, 26 February 2010, viewed 3 March 2010, <http://www.ama.com.au/node/5368>
 35. While formal training for general practice was introduced in the 1970s, it was voluntary, and it remained that medical practitioners who were not specialists, were by default, general practitioners.³⁵ In 1988, a dispute about billing led to the introduction of the general practice vocational register. From that time, general practitioners with recognised qualifications or experience were able to attract higher Medicare rebates for their services. The Howard Government's restriction on the issue of new Medicare provider numbers only to those, including general practitioners, who had completed recognised course of post graduate training leading to the award of a fellowship, however, further confirmed general practice as a specialty. M Bollen and D Saltman, 'A history of general practice in Australia', in Department of Health and Ageing (DOHA), *General practice in Australia 2000*, DOHA, 2000.
 36. Letter to Dr Joanna Flynn, Chair, Medical Board of Australia from Dr Andrew Pesce, Australian Medical Association President, 19 February 2010.
 37. Dr A Pesce, quoted in AMA, *AMA urges Medical Board to recognise thousands of vocationally registered GPs as 'specialist GPs'*, media release, 25 February 2010, viewed 2 March 2010, <http://www.ama.com.au/node/5357>

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Despite opposition to the NRAS from groups such as the AMA, many high profile health commentators have been consistently supportive of the scheme. Professor Peter Brooks, Executive Dean of Health Sciences at the University of Queensland, for example, has argued that the medical profession's criticisms of the scheme amount to another manifestation of 'turf wars' and are about maintaining the power base of the medical profession.³⁸ Brooks believes that for medical practitioners, the national registration scheme will improve the sharing of information and mobility. Professor Nick Zwar has also been supportive of the national scheme concept. He suggests in opposition to claims that it may produce more instances of incompetency, it may be more likely to ensure incompetent doctors are detected and not allowed to practice. It may indeed prevent instances manifest in the Patel case.³⁹

Other supporters of the national scheme have included some sections of the nursing profession and the Consumers Health Forum of Australia (CHF).⁴⁰ The CHF has been supportive of the scheme as it believes it will help to 'protect consumers against the tiny proportion of health professionals who cannot be trusted' and that it will increase 'workforce mobility in the current environment of severe workforce shortages'.⁴¹ It should be noted, however, that the Nursing Federation of Australia, while initially supportive, has recently modified its stance. It has argued this is because of an implied threat to nursing standards under the scheme—a similar concern to that expressed by the medical profession.⁴²

Key Issues

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38. S Lane, 'Interview with P Brooks and N Zwar, 'Doctors divided over national registration scheme' *PM*, transcript, Australian Broadcasting Corporation, 25 March 2008, viewed 2 March 2010, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22emms%2Femms%2F99926%22>
 39. *Ibid.*
 40. Australian Nursing Federation, *National registration supported by nurses*, media release, 26 March 2008, viewed 2 March 2010, <http://www.anf.org.au/>
 41. Consumers Health Forum of Australia, *Health consumers want national registration of health professionals*, media release, 25 March 2008, viewed 2 March 2010, <http://www.chf.org.au/pdfs/med/med-national-registration-health-professionals.pdf>
 42. Thompson, 'Pollies to set medical standards', *op. cit.*

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The complexity of ensuring that all health practitioners are properly qualified and competent has been acknowledged by a number of sources.⁴³ In the case of medical practitioners, a number of articles have suggested that this task has been made more complex as a result of Australia's reliance on overseas trained doctors in the past decade or so. Instances such as the Patel case in Queensland have highlighted the need to introduce uniform and consistent standards across Australia to ensure that practitioners who are inadequately qualified are not registered to practice. As one article notes, it is possible that Patel's 'tainted registration history' was not discovered because the Queensland Medical Board was 'lax per se', or because it was intentionally less thorough because of his area of need appointment or because it presumed Patel was competent because of his experience in the United States.⁴⁴ Whatever the reason for Patel's registration, the instance illustrates the fundamental need for a more reliable and responsive registration process. Similarly, it justifies the objective of creating a cooperative, national system of registration to improve the quality of health care delivery.

From the apparent perspective of Peter Arnold and, to some extent the AMA, better quality care will not be achieved under the NRAS, however, because government does not think in terms of 'standards' of care. Rather, its bottom line is the number of practitioners delivering care. In relation to medical practitioners, from a government point of view according to this line of argument, it is therefore better to have an inadequately trained doctor in an area of need, than no doctor at all. In Arnold's view, the old system worked in terms of standards; what needed fixing was the lack of coordination between governments. In other words, what the professions did was not broke and did not need fixing—the administration was the problem. Under the new system, the devil is likely to be in the administrative details also; that is, in the regulations.

43. For example, Carleton, op. cit.

44. K Harvey and T Faunce., 'A critical analysis of overseas trained doctor (OTD) factors in the Bundaberg base hospital surgical inquiry', *Law in Context*, vol. 23, no. 2, 2006, viewed 4 March 2010, [http://parlinfo/parlInfo/download/library/jrnart/IJXK6/upload_binary/ijxk64.pdf;fileType=application%2Fpdf#search=%22a%20critical%20analysis%20of%20overseas%20trained%20doctor%20\(OTD\)%20factors%22](http://parlinfo/parlInfo/download/library/jrnart/IJXK6/upload_binary/ijxk64.pdf;fileType=application%2Fpdf#search=%22a%20critical%20analysis%20of%20overseas%20trained%20doctor%20(OTD)%20factors%22). Note: areas of need (AON) are determined by state and territory governments for locations where there have been difficulties demonstrated in the recruitment of medical practitioners. The declaration of AON for a position means that the state or territory allows the recruitment and employment of an overseas trained doctor for the time period of the AON determination. AONs can be any location in which there is a lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. AON can apply to both public and private sector positions. Most overseas trained doctors are required to work in an AON when they first come to Australia. If there is no current determination for a required location and position, an application requesting a determination of an AON needs to be assessed by the relevant department of health before an overseas trained doctor can be approved by the state or territory to work in the position.

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It is proposed in this Bill for example, that certain classes of medical practitioners will be specified in the regulations as being able to practise medicine, despite their not being on the general practice or specialist registers (**item 3 and item 9**). That is, if these practitioners are delivering services in accordance with their registration ‘so as not to disadvantage patients’.⁴⁵ Therein may be some of the detail—the variety of interpretations of what amounts to patient disadvantage. It follows from this perspective that the question is: what exactly will the regulations specify as acceptable? Similarly, if the current system has led to cases like Patel, how will the NRAS be different, if this type of ‘loophole’ is still present? And, perhaps the most important question, if non professionals in the form of the Health Ministers are able to direct Medical Boards to register practitioners who do not meet Australian standards in order to fill area of need placements, how is the new system an improvement on the old?

On the other hand, Anne-Louise Carlton makes the point that the model of regulation that has applied to Australia has enshrined the principle that practitioners are the best persons to judge what constitutes professional and unprofessional conduct and how best to protect the public. However, while they may be the best persons to judge clinical and professional expertise, they

... may be ill prepared for a role that requires an understanding of the principles of natural justice and procedural fairness, and they may, at times, lack insight where professional interests conflict with the broader public interest.⁴⁶

It may be, therefore, that the high level oversight of the NRAS at Ministerial level will bring a more comprehensive evaluation of what constitutes the public interest than has been the case under the present scheme. It could be argued that an earlier suggestion by the AMA that Ministerial determinations should be subject to a public interest test is worthwhile in this context, and would be worth reconsideration.⁴⁷

Other issues which may be raised in conjunction with discussion of this legislation may include arguments put by those professions that will not be registered under the National law for their early inclusion. For example, in jurisdictions such as the United Kingdom, paramedics are registered nationally, but in Australia there is ‘no genuine regulation of

45. Explanatory Memorandum, Health Practitioner Regulation (Consequential Amendments) Bill 2010, p. 3, viewed 26 February 2010, http://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r4308_ems_81bf17c9-5d4b-4e82-8d3e-3b6e0227ec69/upload_pdf/339796.pdf;fileType%3Dapplication%2Fpdf

46. Carlton, op cit.

47. AMA, *National registration and accreditation – Queensland must set example for other states*, media release, 7 October 2009, viewed 4 March 2010, <http://www.ama.com.au/node/5014>

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paramedic practice'.⁴⁸ Each state and territory has legislation which governs the delivery of ambulance services and individual services set and monitor their own standards of practice. Paramedic is not considered a restricted or licensed title. Until recently paramedics were referred to simply as ambulance officers. Many people probably still consider that these ambulance officers only provide first aid and pain relief for patients before they are transported to hospital emergency departments for 'real' treatment.

As one commentator notes, there is 'no national regulatory scheme for the independent accreditation of statutory and private contract service providers. Paramedics aren't even listed as allied health professionals by the Commonwealth'. The same commentator notes that other health professionals are not able to practice without registration, yet unregistered paramedics deal with thousands of patients annually, making life and death decisions. This raises 'legitimate questions regarding transparency, public accountability and performance management, which would appear to mandate an independent regulatory and national registration regime'.⁴⁹

Financial implications

According to the Explanatory Memorandum to this Bill, it will have minimal financial impact on the Department of Health and Ageing. While there may be some administrative savings in Medicare resulting from the allocation of fewer resources to the process of specialist recognition, these are likely to be offset 'through improvements in information technology systems'.⁵⁰

The Explanatory Memorandum offers the following background information:

COAG has allocated \$19.8 million over four years for implementation of the NRAS. It had been agreed that this will funding will be provided in accordance with the Australian Health Ministers' Advisory Council cost share formula as shown below.

Jurisdiction	C'wealth	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Amount (\$m)	9.90	3.31	2.45	1.91	0.98	0.75	0.24	0.16	0.10

48. P O'Meara and C Grbich eds, *Paramedics in Australia: Contemporary challenges of practice*, Pearson Education, Frenchs Forest, 2009.

49. R Bange, 'Paramedics forgotten in our health care debate', Crikey webpage, 30 June 2009, viewed 5 March 2010, <http://www.crikey.com.au/2009/06/30/paramedics-forgotten-in-our-health-care-debate/>

50. Explanatory Memorandum, p. 2.

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Main provisions

As mentioned, **clause 2** proposes that the Bill's effective provisions will commence on proclamation. This is apparently necessary because they are dependent on legislation to establish the national scheme being passed by all states and territories.⁵¹

Schedule 1 Part 1

Schedule 1 Part 1 will amend the *Crimes Act 1914* and the *Health Insurance Act 1973*.

Crimes Act 1914

Item 1 will amend the definition of nurse in the Crimes Act, removing the term 'registered'. This is necessary due to the insertion of a new definition in the Health Insurance Act (**item 5**).

Health Insurance Act 1973

Items 2 to 10 propose to amend **subsection 3(1)** of the Health Insurance Act to ensure definitions of certain health practitioners will be consistent with definitions under the NRAS. These amendments, according to the Explanatory Memorandum to the Bill, will more clearly identify the practitioners and 'modernise' the definitions.⁵²

A new definition of 'consultant physician' under **item 2** will remove the need for there to be a determination under **section 3DB or 3E** that a person is recognised under the Act as a consultant physician.

Under the proposed change a consultant physician will be a medical practitioner in relation to a particular speciality if certain conditions are satisfied:

- the medical practitioner is registered in the specialty under the law of a state of territory
- the specialty is prescribed in regulations
- the medical practitioner satisfies any other requirements prescribed by the regulations.

In addition, under this item regulations will be also able to prescribe a class of medical practitioners as consultant physicians if they are not on the NRAS specialist register, but still providing specialty services for which Medicare benefits are payable, and which are in accordance with their registration.

51. Ibid., p. 3.

52. Ibid.

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Item 3 proposes to repeal the definition of ‘general practitioner’ and substitute a new definition. The new definition of general practitioner will be:

- a medical practitioner who is registered under a state or territory law in the specialty of general practice or ‘a medical practitioner of a kind specified in the regulations’.⁵³

The latter aspect of the definition is intended to cover persons who are not on the specialist general practice register, but who, in keeping with the terms of their registration are providing general practice services for which a Medicare benefit is payable.

Item 4 will repeal the definition of ‘medical practitioner’ and substitute a new definition. It is proposed that a ‘medical practitioner’ will be someone registered under a state or territory law as a medical practitioner. According to the Explanatory Memorandum, this revised definition is intended to capture all person registered under the NRAS to practice medicine, apart from students.

The Explanatory Memorandum notes that the revised definition does not replicate paragraphs (a) and (b) of the existing definition. These paragraphs relate to a person whose registration as medical practitioner has been suspended, revoked or cancelled following an inquiry into his or her conduct. Under the NRAS, persons whose registration has been revoked or cancelled in any jurisdiction will not be considered medical practitioners in any jurisdiction nor under the Health Insurance Act. Persons whose registration has been suspended will not be considered medical practitioners during the period of suspension. The net effect is that there is no change to the practical operation of the legislation.

Item 8 repeals the current definition of ‘registered nurse’ in the Health Insurance Act. Currently, a registered nurse is person registered under a state or territory law (except in South Australia) as a general nurse or a person registered under South Australian law as a nurse. **Item 5** proposes to insert a new definition of ‘nurse’. A nurse will be a person enrolled under a state or territory law as a registered nurse (Division 1) or a person enrolled under a state or territory law as an enrolled nurse (Division 2).⁵⁴ As a consequence of the new definition of ‘nurse’ in **item 5** the term registered will also be omitted from the definition of nursing care under **item 6**.

53. Explanatory Memorandum, p. 4.

54. Registered nurses make up the majority of the Australian nursing workforce. These nurses usually require a three-year bachelor or post-graduate degree in nursing, or the equivalent. This degree includes both theoretical and clinical aspects. Enrolled nurses usually work with registered nurses to provide patients with basic nursing care, undertaking less complex procedures than registered nurses. Enrolled nurses must have completed an appropriate vocational education and training course or equivalent, usually of one year’s duration, which provides a theoretical base as well as supervised clinical experience. In addition to having the appropriate qualifications, registered and enrolled nurses are expected to achieve and maintain competence in whatever setting they practise, and to meet guidelines regarding recency of practice.

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It is proposed in **item 9** to repeal the current definition of ‘specialist’ in **sub section 3(1)** of the Health Insurance Act. It is intended that this will be replaced with:

- a medical practitioner will be a specialist in relation to a particular specialty if he or she is registered in the specialty under the law of a state or territory, the specialty is prescribed in the regulations as a specialty and the practitioner satisfies any other requirements in the regulations relating to the specialty. The definition of specialist will also apply to a class of specialist as prescribed in the regulations.

As will apply in the **item 3** definition of general practitioner, this application of the definition of specialist potentially includes another class of practitioner. It is intended by the Government that this will be able to capture those medical practitioners who may not be on the specialist register under the NRAS, but who are nevertheless providing services related to a specialty, in accordance with their registration and for which Medicare benefits are payable.

The Explanatory Memorandum notes that although the definition of specialist under the revised Act will include the specialty of general practice, there will remain a distinction between general practice and other specialties in the Health Insurance Act. This will be to accommodate the differences in Medicare items for general practitioners as opposed to other specialties.⁵⁵

Item 11 proposes to repeal a number of sections in the current Health Insurance Act. These sections apply to the current processes for recognition of specialists and consultant physicians under the current system. Under the NRAS, the Medical Board of Australia in conjunction with Australian Health Practitioner Regulation Agency will maintain a specialist register of all medical practitioners who are registered as specialists.

Item 12 proposes to substitute a new definition of ‘medical college’ which will be required as it is proposed to repeal **section 3D** under which medical college is currently defined. The new definition proposes that a ‘medical college’ is:

- an organisation accredited by the Australian Medical Council as a specialist medical college and
- specified by the Minister in writing to the Medical Training Review Panel for that purpose.

Items 14 to 21, according to the Explanatory Memorandum, propose to ‘modernise’ the language used in certain subsections of **section 19C** and **section 19CB** of the Health Insurance Act. The intention is not to make substantive changes to the sections.

Schedule 1 Part 2

55. Explanatory Memorandum, p. 4.

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Items 26 to 29 in this Schedule deal with transitional provisions. **Item 26** will insert new definitions. It is proposed that ‘commencement time’ will mean the time the Schedule commences. ‘New law’ will mean the *Health Insurance Act 1973* as in force after the commencement time, and ‘old law’ will mean the *Health Insurance Act 1973* which was in force immediately before commencement time.

Item 27 will provide that the Governor General may make regulations to ensure that persons who, before the commencement time of the Schedule to this Bill, were vocationally registered general practitioners under **section 3F**, will continue to be considered as ‘general practitioners’ for a ‘period specified in the regulations’. It is proposed this will be the case even if those practitioners do not meet the new definition of general practitioner to be inserted under **item 3**. The Explanatory Memorandum notes that this transitional provision is intended ‘to offer flexibility to deal with people who may be affected by the introduction of the NRAS and the amendments made to [the Health Insurance Act]’.⁵⁶ The provision will also cover practitioners who have outstanding applications or appeals before the General Practice Recognition Eligibility Committee or the General Practice Recognition Appeal Committee.

Items 28 and 29 will provide that directions made by the Minister relating to payment of Medicare benefits prior to the commencement of the Schedule to this Bill continue to be in force after the amendments to those subsections come into force.

Concluding comments

This Bill will make a number of changes to federal legislation, most specifically, to the Health Insurance Act, to accommodate the introduction of the NRAS. The proposed changes appear generally to be uncontroversial. Issues associated with the National Law overall may be more likely to elicit comment, however. In particular, health profession stakeholders, particularly the medical and nursing professions may use discussion surrounding this Bill to iterate concerns about government oversight of accreditation standards. There could be some lobbying by professions which will not be registered under the National Law also for inclusion under the NRAS.

Further, the medical profession may question an apparent ‘loophole’ which is likely to give the government the ability to allow classes of medical practitioners, who may not be qualified to Australian standards, to practise as general practitioners or other medical specialists. The issues will be whether the aims of the NRAS will indeed be undermined by this situation, and whether the potential for another Patel case remains. On the other hand, it is difficult to see what alternative the government has to allowing the flexibility to register non Australian trained medical practitioners to work in areas of need, given that reliance on overseas trained doctors will continue in rural and remote Australia for some years to come.

56. Ibid., p. 9.

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