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Health Practitioner Regulation (Consequential Amendments) Bill 2010

The AMA is pleased that the Senate Community Affairs Committee is conducting an inquiry into the Health Practitioner Regulation (Consequential Amendments) Bill 2010 (the Bill). The Bill effectively represents the Commonwealth's implementation of the National Registration and Accreditation Scheme for the Health Professions (the new scheme), however, it is focussed only on provisions relating to the Medicare benefits arrangements that require consequential amendment.

The AMA has devoted considerable effort to ensuring that the new scheme does not compromise patient safety and quality of care. To that end, the AMA was able to secure some critical elements such as the separation of the accreditation function from registration, the adoption of the existing accreditation standards for medicine, and the Medical Board (not the Ministerial Council) approving accreditation standards. However, we have some important residual concerns with the *Health Practitioner Regulation National Law* (the National Law) that is progressing through each state and territory Parliament, some of which we believe can be addressed by the Federal Parliament in the Bill before it.

The Bill

We have concerns about two particular aspects contained in the Bill:

1. new provisions that would allow Government to impose additional requirements on consultant physicians and specialists in order to be eligible for Medicare benefits; and
2. the failure to restrict the payment of Medicare benefits for services provided by <u>all</u> nationally registered health professionals that are outside the scope or conditions of their registration.

Eligibility for Medicare benefits

The Bill removes all of the existing provisions in the *Health Insurance Act 1973* that clearly set out the requirements that consultant physicians, specialists, and general practitioners have to meet to be eligible for Medicare benefits, i.e. to be recognised

and obtain a provider number as a consultant physician, specialist or general practitioner.

In respect of consultant physicians and specialists, items 2(a) and 9(a) in Schedule 1 respectively will require them to be a medical practitioner that is registered in a speciality by the Medical Board of Australia, where the speciality is prescribed by regulation. This is broadly similar to the existing arrangements.

However, the Bill introduces new provisions that would allow Government to impose additional requirements on consultant physicians and specialists – see subitems 2(a)(iii) and 9(a)(iii) in Schedule 1. The explanatory memorandum provides no clues as to why these new provisions are needed, and when and why they would be used now or in the future. Consequently, the provision provides an open ended power without any clear purpose.

The AMA is aware that the current trend in legislative drafting is to give Government flexibility by including regulation making powers to deal with the detail. But with this particular Bill, the AMA questions why, at the threshold level, registration with the Medical Board of Australia, and the conditions the Board might impose on an individual registrant's practice, is not sufficient for eligibility for Medicare benefits purposes for consultant physicians and specialists.

The AMA notes that the Government is not seeking the same provisions and regulatory powers in respect of general practitioners, or any of the other health professions, for the purposes of Medicare eligibility.

Accordingly, the AMA recommends that the Bill be amended to remove subitems 2(a)(iii) and 9(a)(iii) from Schedule 1.

For clarity, the AMA wishes to confirm that it agrees that subitems 2(b), 3(b) and 9(b) are needed whereby the regulations can prescribe classes of consultant physicians, general practitioners and specialists who are not on the Medical Board of Australia specialist register. However, we note that these technical provisions are worded differently even though the explanatory memorandum describes the provisions as having the same intended effect.

Accordingly, we recommend that the Bill be amended so that subitems 2(b) and 9(b) are worded as per subitem 3(b).

Restriction of benefits for services beyond the scope of registration
Section 19C of the *Health Insurance Act 1973* effectively restricts the payment of Medicare benefits for services provided by a medical practitioner that are outside the scope of the practitioner's registration, e.g. where the Medical Board imposes restrictions or conditions on the services a registrant can provide. Sections 19CB, 19CC and 19DA broadly provide for offences where a medical practitioner renders an unauthorised service or is not registered when a service was provided and a Medicare benefit was paid for the service.

The Bill makes some minor amendment to these sections to reflect contemporaneous language used in the new scheme, e.g. "practitioner's licence" becomes "practitioner's registration".

With the introduction of national registration for ten health professions, and the extension of the Medicare benefits arrangements to a wider range of health professions, it is appropriate that the same statutory obligations and offences that apply to the medical profession in respect of Medicare benefits should apply to all nationally registered health professionals whose services attract Medicare benefits.

Accordingly, the AMA recommends that the Bill be amended to extend the application of sections 19C, 19CB and 19DA to chiropractors, dental practitioners, nurses, optometrists, osteopaths, physiotherapists, podiatrists and psychologists[1], and in the future to any other health professions that are nationally registered under the new scheme and whose services attract Medicare benefits.

Concerns about the National Law

While the AMA appreciates that the Committee's terms of reference for this particular inquiry do not extend to the National Law for the new scheme, we would like to advise the Committee that we still have concerns about two issues which we believe can be addressed through this Federal legislation:

- the Ministerial Council applying a public interest test before making directions about accreditation standards for health professional education and training standards; and
- exempting treating doctors and doctors working in health advisory services from mandatory reporting obligations.

Public interest test

The Committee will recall its recommendation in its report to the Senate dated 6 August 2009 that the Australian Health Workforce Ministerial Council should consider and evaluate the amendments proposed by the AMA in respect of its directions to registration boards on accreditations standards. The AMA was particularly keen for the National Law to require the Ministerial Council to apply a public interest test. However, Federal, State and Territory Governments did not accept this. Consequently, the National Law as currently passed in Queensland, NSW, Victoria and the ACT only requires the Ministerial Council to *consider* the potential impact of its directions on the quality and safety of care rather than to apply a formal public interest test before issuing such directions.

As the Federal Minister for Health and Ageing is a member of the Ministerial Council, we believe that the Federal Parliament can require the Federal Health Minister to apply a public interest when contributing to decisions of the Ministerial Council.

[1] Pharmacists will be registered under the new scheme but their services do not attract Medicare benefits.

We therefore recommend the Bill be amended to add the following provision:

> The Federal Minister for Health and Ageing, in exercising functions as a member of the Australian Health Workforce Ministerial Council in relation to the giving of directions to National Boards about proposed accreditation standards or proposed amendments of accreditation standards under Part 2 section 11 (3)(d) and (4) of the Schedule to the Health Practitioner Regulation National Law Act 2009 (QLD), must have regard to the public interest.

Mandatory reporting exemptions

The Committee will recall it took substantial evidence on the myriad of risks of introducing mandatory reporting and the particular need to exempt from the mandatory reporting requirements those doctors who are in a therapeutic relationship with other doctors. It is important not to create a situation where health professionals will not seek treatment when they need it.

While we recognise that the Federal Parliament is limited in its ability to influence amendments to the National Law on this issue, we recommend that the Committee ask the Federal Minister for Health and Ageing to monitor the impact of the mandatory reporting provisions and report to the Federal Parliament annually on the impact, operation and outcomes of the mandatory reporting provisions.

I urge the Committee to consider the role the Federal Parliament can take in respect of ensuring the new scheme achieves its primary objectives.

Yours sincerely

Dr Andrew Pesce
President

26 March 2010