Health Practitioner Regulation (Consequential Amendments) Bill 2010

Reference

1.1 On 24 February 2010, the Hon Nicola Roxon MP, Minister for Health and Ageing, introduced the Health Practitioner Regulation (Consequential Amendments) Bill 2010 (the bill) into the House of Representatives.[1] On 25 February 2010, the Senate, on the recommendation of the Selection of Bills Committee, referred the provisions of the bill to the Community Affairs Legislation Committee for inquiry and report by 9 May 2010.[2] On 16 March 2010, the reporting date was changed to 11 May 2010.[3]

Conduct of the inquiry

1.2 Notice of the inquiry was posted on the committee's website and advertised in *The Australian* newspaper, calling for submissions by 9 April 2010. The committee also directly contacted a number of interested parties, organisations and individuals to notify them of the inquiry and to invite submissions. Twelve submissions were received as listed in Appendix 1.

1.3 The committee considered the bill at a public hearing in Canberra on 30 April 2010. Witnesses who appeared before the committee are listed at Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the committee's website at: http://www.aph.gov.au/Senate/committee/clac_ctte/index.htm.

1.4 The committee thanks those who assisted with the inquiry.

Purpose of the bill

1.5 The stated purpose of the bill is to make consequential and transitional amendments to Commonwealth legislation required to recognise and support the implementation of the National Registration and Accreditation Scheme for Health Professions (NRAS).[4] It ensures definitions of health practitioners in the *Health Insurance Act 1973* (HIA) are consistent with the NRAS and also streamlines the processes to recognise doctors for Medicare purposes under the HIA.[5]

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1 *House of Representatives Hansard*, 24 February 2010, p. 1643.

2 *Senate Hansard*, 25 February 2010, p. 1241.

3 *Senate Hansard*, 16 March 2010, p. 1914.

4 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 24 February 2010, p. 1.

5 Explanatory Memorandum, p. 1, 3.

Background to the bill

1.6 In 2004 the Council of Australian Governments (COAG) agreed to commission a paper on health workforce issues,[6] and in 2005 the Productivity Commission was asked to undertake this task. Among its recommendations was the establishment of a national registration board for health professionals as well as a national accreditation board for health professional education and training.[7]

1.7 In response to the recommendations, on 14 July 2006 COAG agreed to establish a national registration scheme for health professionals and a national accreditation scheme for health education and training.[8] In April 2007, COAG subsequently agreed to establish a single national scheme, with one national agency covering both the registration and accreditation functions. It was intended to commence in July 2008 and apply to nine health professions.[9]

1.8 With implementation delayed by the federal election in 2007, at the 26 March 2008 COAG meeting an Intergovernmental Agreement (IGA) to implement the NRAS (the scheme) by 1 July 2010 was signed. It contained the following objectives:

- provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- facilitate workforce mobility and reduce red tape for practitioners;
- facilitate the provision of high-quality education and training and rigorous and responsive assessment of overseas-trained practitioners;
- to have regard to the public interest in promoting access to health services; and
- to have regard to the need to enable the continuous development of a flexible, responsive and sustainable health workforce and enable innovation in education and service delivery.[10]

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6 See 25 June 2004 COAG Communiqué available from: http://www.coag.gov.au/coag_meeting_outcomes/2004-06-25/index.cfm#health accessed 4 March 2010.

7 Productivity Commission Research Report, *Australia's Health Workforce*, 22 December 2005, p. 111 and p. 133.

8 See 14 July 2006 COAG communiqué available from http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm#health accessed 2 March 2010.

9 See 13 April 2007 COAG Communiqué available from: http://www.coag.gov.au/coag_meeting_outcomes/2007-04-13/index.cfm#health accessed 2 March 2010.

10 Intergovernmental Agreement, p. 3.

Consultation

1.9 Extensive consultation has been undertaken with stakeholders regarding the development of the scheme. During 2008 and 2009 the National Registration and Accreditation Implementation Project (NRAIP) conducted a comprehensive national consultation process.[11] A number of changes were made to the original proposal as a result of stakeholder feedback, and this was acknowledged during the committee's previous inquiry (see below, from paragraph 1.14).

Implementation

1.10 The Australian Constitution provides that the power to regulate health professions resides with the states. This prevents the Commonwealth from enacting the NRAS through a single piece of Commonwealth legislation. Instead, an 'applied laws' model is being used. The scheme is to be established through state and territory laws, with a finalised National Law being enacted in Queensland and then adopted by the other states and territories. Each state and territory will repeal existing laws covering the functions to be performed by the new system.[12] This process is described below:

- Queensland is the lead state. The first tranche of legislation, *The Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 (Qld)*, known as Act A, established the structure and functions of the NRAS including the new national agency, the Australian Health Practitioner Regulation Agency (AHPRA);
- the second tranche of legislation, the *Health Practitioner Regulation National Law Act 2009 (Qld)*, known as bill B or the 'National Law', received Royal Assent on 3 November 2009. It details the substantive provisions for registration and accreditation and replaces the first tranche of legislation (Act A); and
- the third tranche of legislation involves states and territories passing legislation to apply the National Law and to include jurisdiction-specific consequential and transitional provisions. These are referred to as bill C. The bill currently before the committee is the Commonwealth equivalent of bill C.[13] (a diagram showing the relationship of the bills is at Appendix 3)

1.11 Victoria and the Australian Capital Territory have passed legislation to adopt the National Law, and consequential amendments laws have also been passed. The

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11 Refer to the website: http://www.nhwt.gov.au/natreg.asp. See also Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 22.

12 Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, August 2009, p. 3.

13 Explanatory Memorandum, p. 1 and Ms Maria Jolly, Acting First Assistant Secretary, Health Workforce Division, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 22.

adoption law has also been passed in New South Wales and the Northern Territory. The adoption and consequential legislation is pending introduction in South Australia and Western Australia and re-introduction in Tasmania.[14]

1.12 The Commonwealth does not need to apply the Act for the National Law and hence only consequential and transitional amendments to Commonwealth legislation are required to recognise and support the NRAS.[15] This includes modernising and aligning definitions so they are consistent with the National Law and making amendments to the HIA to ensure that medical practitioners continue to retain the same Medicare billing eligibility from 1 July 2010.[16]

Governance

1.13 The IGA notes that the NRAS will consist of a Ministerial Council comprised of all health ministers, 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.[17]

Scope

1.14 The new scheme will for the first time create a single national registration and accreditation system for ten health professions: chiropractors; dentists (including dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists.[18] Other health professions will be added over time. On 8 May 2009, the Australian Health Workforce Ministerial Council (AHWMC) advised that from 1 July 2012 a further three professions will be regulated under NRAS: Aboriginal and Torres Strait Islander health practice; Chinese medicine; and medical radiation practice.[19] On 27 August 2009, the AHWMC decided to include occupational therapists in the scheme from the same date.[20]

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14 DoHA, *Submission 11*, p. 3.

15 Explanatory Memorandum, p. 1.

16 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 24 February 2010, p. 1643 and Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, pp 22-23.

17 Intergovernmental Agreement, p. 2.

18 Information available from http://www.nhwt.gov.au/natreg.asp accessed 4 March 2010.

19 AHWMC Communiqué 8 May 2009 available from: http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Design%20of%20new%20National%20Registration%20and%20Accreditation%20Scheme.pdf accessed 4 March 2010.

20 AHWMC Communiqué, 27 August 2009, p. 2.

Previous committee report

1.15 The NRAS is familiar ground for this committee. On 6 August 2009, the Community Affairs Legislation Committee reported on the exposure draft of the main piece of legislation implementing the NRAS and made three recommendations. The background to the National Law has been briefly covered in this report, and the committee refers readers who are unfamiliar with its history to the further detail in the committee's earlier report.[21]

Treatment of the issues raised during the previous inquiry

1.16 Before turning to the main provisions of the bill currently before it, the committee will briefly report on the outcomes of the recommendations made during its previous inquiry.

Independence of accreditation processes

1.17 The main issue raised during the committee's previous inquiry was the independence of accreditation processes under NRAS and the ability of the Ministerial Council to give directions on accreditation standards. During the committee's earlier inquiry, witnesses acknowledged that improvements had been made to the legislation in this area as a result of consultation, but concerns remained. The main problem was a perceived tension between public safety and workforce planning issues which may mean that a directive regarding workforce planning outcomes might compromise public safety and quality. The committee agreed that safeguards would enhance confidence in the new system and recommended that the AHWMC consider the amendments proposed in this area to clauses 10(3) and 10 (4) of bill B (the National Law), particularly those made by the Australian Medical Association.[22]

1.18 The committee notes that the National Law now contains the requirement that the Ministerial Council must consider the potential effect of a direction on the quality and safety of health care.[23]

1.19 It appears, however, that the AMA's concerns have not been assuaged by this amendment. An AMA media release in August 2009 noted the requirement for ministers to give consideration to quality and safety but argued that there is no guarantee they would act on this consideration. In its opinion 'Ministers have failed to guarantee that they would put quality and safety and other public interest considerations ahead of workforce supply considerations'. The AMA called for

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21 Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, August 2009.

22 Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, August 2009, p. 14.

23 Australian Health Workforce Ministerial Council, Communiqué, *Ministers Consider Submissions on Legislation on National Registration Scheme*, 27 August 2009, p. 1.

ministers to undertake a full public interest test before exercising the power to issue a direction in relation to accreditation standards. The AMA said that in the short term it would call on each state parliament to amend the bill in accordance with its calls for a public interest test.[24] As this issue was raised again as part of the current inquiry, it is further discussed below from paragraph 1.57.

Directions by the Ministerial Council

1.20 The committee further recommended that the reasons for the Ministerial Council issuing a direction in relation to an accreditation standard be made public.[25] The committee notes that the legislation requires a copy of any direction by the Ministerial Council to the National Agency or to a National Board to be published on the relevant website and in the annual report.[26]

Composition of national boards

1.21 Responding to concerns about the composition of the National Boards, the committee considered that the power given to the Ministerial Council to decide the size and composition of the National Boards should not be overly constrained by the formula in the exposure draft. Accordingly, the committee's third recommendation was for the AHWMC to ensure that the NRAS contain sufficient flexibility to ensure that the composition of National Boards properly reflects the characteristics and needs of the individual professions.[27]

1.22 On 31 August 2009 the appointments to National Boards were announced by the AHWMC. It reported that ministers took into account the feedback received on the size and composition of the boards and revisited their decision of 8 May 2009. It was decided that six of the boards should be expanded to include eight practitioner members and four community members each. This enables a practitioner member from each of the eight jurisdictions to be members of these boards. The six boards to be expanded from nine to twelve members are: the Dental Board of Australia, the Medical Board of Australia, the Nursing and Midwifery Board of Australia, the Pharmacy Board of Australia, the Physiotherapy Board of Australia and the Psychology Board of Australia. In addition, ministers decided that the practitioner

24 AMA, 'NRAS Bill still fails the public interest test', *Media Release*, 28 August 2009.

25 Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, August 2009, p. 48.

26 Australian Health Workforce Ministerial Council, Communiqué, *Ministers Consider Submissions on Legislation on National Registration Scheme,* 27 August 2009, p. 1.

27 Senate Community Affairs Legislation Committee, *National registration and accreditation scheme for doctors and other health workers*, August 2009, p. 49.

members of the Dental Board of Australia would comprise five dentists, one dental therapist, one dental hygienist and one dental prosthetist.[28]

Main provisions of the Health Practitioner Regulation (Consequential Amendments) Bill 2010

Streamlining the recognition of doctors for Medicare purposes

1.23 Schedule 1, Part 1, Item 11 repeals a number of sections in the HIA to streamline recognition for Medicare purposes. There are a number of pathways for specialist, consultant physician and general practitioner (GP) recognition for Medicare purposes under the HIA. Currently these involve liaison by Medicare Australia with a number of bodies, such as medical colleges, to establish eligibility. NRAS provides a nationally consistent means of identifying specialists and GPs. Under the NRAS, the Medical Board of Australia (MBA)—the new national board responsible for registering medical practitioners—in conjunction with the AHPRA will maintain a 'specialists register' which will record all medical practitioners who are registered as a specialist under the National Law. The minister will no longer be required to make determinations in relation to a medical practitioner, which will simplify the processes for specialist recognition for Medicare purposes. Therefore sections 3D, 3DA, 3DB, 3DC and 3E of the HIA are redundant and are repealed by the bill.[29]

1.24 There are three pathways in the HIA for a GP to be recognised. The current Vocational Register of GPs will be removed, and the MBA is considering the eligibility requirements for the GP speciality register.[30] As a result of the new arrangements, sections 3EA, 3EB, 3F and 3G of the HIA are redundant and are repealed by the bill.[31]

1.25 Schedule 1, Part 2, Items 26 to 29 deal with transitional provisions.

Issues raised during the current inquiry

1.26 Submissions to the inquiry showed strong support for the introduction of national registration and accreditation for health professions. The proposed changes to Commonwealth legislation to support the introduction of the NRAS in the bill were also generally supported. However, some technical issues were raised with the committee and are discussed below. Some issues with the National Law were also raised with the committee. Although these do not fall within the scope of the bill and

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28 Australian Health Workforce Ministerial Council Communiqué, 'Health Ministers Announce Appointments to National Boards for the National Registration and Accreditation Scheme, 31 August 2009, p. 1.

29 Explanatory Memorandum, pp 6-7.

30 On 25 February 2010 the Medical Board of Australia announced its decision to include vocationally registered GPs on the Specialist Register of the new national registration scheme.

31 Explanatory Memorandum, p. 7.

therefore cannot be directly addressed by the committee's current inquiry, these are also discussed briefly below from paragraph 1.57.

Definitions

1.27 Schedule 1, Part 1, Items 2 to 10 amend subsection 3(1) of the HIA to make a number of definitional changes to ensure definitions of health practitioners in the HIA are consistent with the NRAS.[32]

Nursing

1.28 The Australian Nursing and Midwifery Council (ANMC) noted that the proposed definition to be included in the *Health Insurance Act 1973*, section 5 subsection 3(1)(a)(b), includes reference to registered nurse (Division 1) and enrolled nurse (Division 2). The ANMC submitted that the inclusion of 'Division 1' and 'Division 2' in the definition of registered and enrolled nurse is not appropriate as it is not nationally accepted terminology and will lead to confusion.[33]

1.29 This view was supported by the Australian Nursing Federation (ANF), which argued that the terms Division 1 and Division 2 are only used in Victoria and are therefore not common nor accepted terminology for the nursing profession.[34]

1.30 The Department of Health and Ageing explained to the committee that one of the purposes of bill C is to ensure that the definitions in the HIA are consistent with the National Law:

> The term 'division' [in the National Law] is meant to apply to any health professional group that chooses to divide themselves for the purposes of registration. I understand the terms 'division 1' and 'division 2' have a history [in nursing], but for the purposes of the national law it is the definition of division that is picked up...[35]

1.31 Officials further explained that one definition for nurses in the National Law (section 222) is for the purposes of registration only. On the register of nurses and on their registration record there are registered nurses (Division 1) and enrolled nurses (Division 2). Bill C uses the term 'division' as that is what is used in the National Law and the objective is to achieve consistency for the purposes of access to Medicare. The other, and more relevant definition, is the way in which health professionals refer to themselves and the title by which they will be known. Professional titles are protected

32 Explanatory Memorandum, p. 3.

33 Australian Nursing and Midwifery Council, *Submission 5*.

34 Australian Nursing Federation, *Submission 10*, p. 2.

35 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 23.

in the National Law (section 114). The protected titles include 'nurse', 'registered nurse', 'nurse practitioner' and 'enrolled nurse', among others.[36]

1.32 Importantly, under the National Law, there are penalties for any individuals who misuse titles, and these penalties are referenced to the list of protected titles.[37]

Committee view

1.33 The committee notes that in order to change the definition of nurses in bill C the National Law would need to be amended in every jurisdiction. The Ministerial Council would first need to consider any proposed amendments and, if agreed, a legislative amendment would need to go through the Queensland Parliament. If passed, the other states and territories would incorporate the changes by applying the amendment as a law of those jurisdictions.[38] While this process does not deter the committee from recommending necessary amendments, the committee understands that the alignment of definitions with the National Law is to ensure continued access to Medicare.

1.34 The committee was reassured by the department that there should be no change to the way in which nurses describe themselves and was told that there is no intention for this to occur. Nurses will be covered by protected titles, as will other professional groups. The committee notes that there are four other professions that have titles listed under section 222 of the National Law under the heading 'Divisions of public national register'.[39]

Nursing care

1.35 The ANF also expressed concern about the proposed removal of the word 'registered' from the definition of 'nursing care'. It explained that there is a difference in the accountability level of a registered nurse and an enrolled nurse:

> Enrolled nurses work under the supervision and direction of registered nurses. Registered nurses are educated and qualified to assess and delegate nursing care to other registered or enrolled nurses. The removal of registered from the definition of nursing care becomes problematic then as this distinction in accountability level is lost.[40]

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36 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 23.

37 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 24.

38 Intergovernmental Agreement, pp 7-8.

39 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 25.

40 Australian Nursing Federation, *Submission 10*, p. 2.

1.36 To address this issue, the ANF recommended that the wording for the definition of 'nursing care' should become 'nursing care means care that is given by a nurse or under the supervision of a registered nurse'.[41]

1.37 The Department of Health and Ageing explained that the term 'registered' now has several meanings:

> If you are a 'registered nurse', you may be an enrolled nurse or you may be a registered nurse. Because the term now has several meanings, the suggestion was to amend the current way it is defined, again in order for it to be consistent with the national law. There is no intention in that to change who provides nursing care, how that is structured or any of the arrangements in place around supervision. None of those things are intended. It is an issue of consistency with what is in the national law.[42]

Committee view

1.38 The committee understands that a registered nurse may mean a nurse on the register or the protected title of registered nurse. In the case of 'nursing care', it means a nurse on the register. The committee accepts that the wording is to ensure consistency of the National Law and the HIA and that there is no intention to change who provides nursing care or any arrangements in place around supervision. The committee also notes the willingness of the department to work with the ANF on this issue to explore suitable alternative approaches.[43]

Other definitions

1.39 The Royal Australasian College of Physicians questioned the revised definition of a 'consultant physician', finding it to be too open. It also suggested clarification is needed regarding the terms 'specialist' and 'consultant physician'.[44] The Australian Society of Plastic Surgeons (ASPS) submitted that the new application of the word 'specialist' will result in a lack of clarity, which in turn will impose an increased level of responsibility on the consumer to distinguish the qualifications of the practitioner. It advocated that 'the only title that should be used by a practitioner is the title for which they trained'. The ASPS noted the work of the MBA to define the use of specialist titles but stated that it remains concerned about a consumer's ability to discern and determine whether the scope of practice undertaken by a practitioner is within the accredited training of that practitioner.[45]

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41 Australian Nursing Federation, *Submission 10*, p. 3.

42 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 26.

43 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 26.

44 The Royal Australasian College of Physicians, *Submission 6*, p. 1.

45 Australian Society of Plastic Surgeons, *Submission 7*, pp 2-3.

1.40 The committee notes the significant protections for the public in the National Law against individuals who call themselves specialists but are not qualified to do so. The MBA has recently stated:

> The fields of practice included on the specialist register closely mirror the fields of practice on the Australian Medical Council's specialist list…
>
> Some professional associations and Colleges submitted that the Board should protect many commonly used titles for each profession. Concerns were expressed that nonqualified persons may use the titles that are not protected and therefore compromise public safety. The Board chose to protect a single title for each field of practice and noted that the National Law imposes significant protections for the public against individuals who hold themselves out to be specialists and are not qualified to do so. This law applies regardless of whether or not the specific title was protected. Fines of up to $30,000 are applicable. In this way, the specialist register will be an additional safeguard for the public.[46]

1.41 Professor John Horvath, Principal Medical Consultant, Department of Health and Ageing, also explained this aspect to the committee:

> ...There are very harsh penalties. To claim to hold a type of registration or endorsement under this law that the practitioner does not hold—it is very clear. A specialist obstetrician can only call themselves a specialist obstetrician if they are on the specialty register of the Medical Board of Australia. That is very clearly defined in section 119 of the act, and it goes on. In the case of an individual who is not a specialist obstetrician and calls themselves a specialist obstetrician, the fine is $30,000.[47]

Committee view

1.42 The committee understands that professional titles will be protected and that there is no intention to change the way health professionals refer to themselves. It also notes the penalties for individuals misrepresenting themselves.

1.43 However, given the issues raised in this section regarding definitions and the importance of ensuring there is no confusion in the community, the committee believes that it would be helpful for AHPRA to provide information on protected titles and roles, including for nurses and specialists, on its website.

Recommendation 1

1.44 To ensure clarity around definitions for the community, the committee recommends that the Australian Health Practitioner Regulation Agency (AHPRA) place information on protected titles and roles, including for nurses and specialists, on its website.

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46 Medical Board of Australia, Communiqué, 24 February 2010.

47 Professor John Horvath, *Proof Committee Hansard*, 30 April 2010, p. 32.

Additional requirements for consultant and specialist medical practitioners

1.45 Items 2(a) and 9(a) in Schedule 1 require consultant physicians and specialists to be a medical practitioner who is registered in a speciality by the MBA, where the speciality is prescribed by regulation. The Australian Medical Association (AMA) noted that this is broadly similar to the existing arrangements. However, the AMA pointed out that items 2(a)(iii) and 9(a)(iii) introduce new provisions that would allow the government to impose additional requirements on consultant physicians and specialists**.** It added that no clear explanation is provided for this open-ended power. The AMA observed that the government is not seeking the same provisions and regulatory powers for general practitioners or any other health profession for Medicare eligibility and recommended that subitems 2(a)(iii) and 9(a)(iii) be removed.[48]

1.46 The Royal Australian College of General Practitioners (RACGP) supported the AMA position and stated that it does not believe the subsections are necessary 'given that consultation physicians and specialists would already be required to be registered and on the specialist register to attract Medicare benefits'.[49]

1.47 The Department of Health and Ageing explained that the intention of bill C is to take the current arrangements and describe them for the purposes of the new National Law. Regarding this particular issue, officials explained the intention:

> At the moment under Medicare if you are a specialist there is a determination as such, and if you are a consultant physician there is a determination as such. One of the opportunities for bill C was to streamline that arrangement so that you did not have to have determinations, and there are a small group of professionals who are both consultant physicians and specialists. The clause that is there was meant to pick up that group so that it did not have to go through dual processes. It was a transition from what currently happens under a banner of, 'We want to make it easier in the future, so we need to pick it up, for drafting purposes, in the new bill.'[50]

1.48 Departmental officials reported that they are investigating whether Medicare still requires a mechanism to distinguish this group and undertook to advise the outcome. The committee was encouraged to hear the willingness of the department to work with the AMA to find a suitable outcome for this drafting issue.[51]

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48 Australian Medical Association, *Submission 3*, pp 1-2.

49 RACGP, *Submission 8*, pp 2-3.

50 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 28.

51 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 28.

Ability for regulations to prescribe classes of consultant physicians, general practitioners and specialists

1.49 Subitems 2(b), 3(b) and 9(b) are intended to cover persons who are not on the general practice or specialist registers but who provide services related to a speciality or general practice services, in accordance with their registration and for which Medicare benefits are payable.[52]

1.50 The AMA confirmed the need for subitems 2(b), 3(b) and 9(b) where the regulations can prescribe classes of consultant physicians, general practitioners and specialists who are not on the MBA specialist register. However, it noted the difference in wording between subitems 2(b), 3(b) and 9(b) and recommended that subitems 2(b) and 9(b) be worded as per subitem 3(b).[53]

1.51 Again, the committee notes the general willingness of the department to work with the AMA to resolve any drafting issues.

Restriction of Medicare benefits for services beyond the scope of registration

1.52 The AMA recommended 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.[54] These sections broadly provide for offences where a medical practitioner provides an unauthorised service or was not registered when a service was provided and a Medicare benefit was paid for the service. The AMA argued:

> …with the introduction of national registration for ten health professions and the extension of Medicare benefit 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 Medicate benefits.[55]

1.53 The RACGP supported this position and argued:

> In a national registration scheme, it is appropriate for the same statutory obligations and offences to apply to all health professions covered by the legislation.[56]

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52 Dr Rhonda Jolly, *Health Practitioner Regulation (Consequential Amendments) Bill 2010*, Bills Digest no. 132, 11 March 2010, pp 16-18.

53 Australian Medical Association, *Submission 3*, p. 2.

54 Note: Pharmacists will be registered under the new scheme but their services do not attract Medicare benefits.

55 Australian Medical Association, *Submission 3*, p. 3.

56 RACGP, *Submission 8*, p. 3.

1.54 Departmental officials acknowledged that the restrictions are currently applied only to medical practitioners and agreed this needs to change for the new system to reflect the fact that the range of health professionals accessing Medicare has changed.[57] The committee notes that the department is working on resolving this drafting issue.[58]

Issues raised with the committee regarding NRAS or the National Law

MBA registration fees

1.55 The AMA told the committee that registration fees for the medical profession are 'likely to be increased by nearly 85 per cent of the current weighted national average registration fee'.[59] The Department of Health and Ageing responded that this issue is not settled:

> …The Australian Health Practitioner Regulation Agency (AHPRA) has not published the fee schedule for the practitioners under the National Registration and Accreditation Scheme for health professions. AHPRA is working with the ten National Boards considering fees for applications and annual renewals. Fees will be announced in June once final information about assets and liabilities transferring to the national scheme is available.[60]

Committee view

1.56 The committee notes that fees are to be set by the 10 National Boards and AHPRA; and that this issue is not addressed by the bill before the committee.

Community representatives on boards

1.57 Each of the 10 national boards has at least two community members appointed.[61] The Consumers Health Forum (CHF) emphasised that these are community members, not consumer members.[62]

1.1 The CHF told the committee that the opportunity for consumers to contribute to the scheme through community members on the boards would be a positive step.[63] Ms Carol Bennett, Executive Director, CHF, indicated to the committee that it will be

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57 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, pp 30-31.

58 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 31.

59 Mr Francis Sullivan, Secretary General, Australian Medical Association, *Proof Committee Hansard*, 30 April 2010, p. 15.

60 Department of Health and Ageing, answer to question taken on notice at 30 April 2010 hearing.

61 See AHWMC, Communiqué, 27 August 2009, p. 2.

62 Ms Carol Bennett, CHF, *Proof Committee Hansard*, 30 April 2010, p. 4, 6.

63 Ms Carol Bennett, CHF, *Proof Committee Hansard*, 30 April 2010, p. 1.

important for the community members to have the opportunity to engage with each other and to obtain broader community and consumer feedback. However, she pointed out that currently they are bound by confidentiality provisions. She stressed the value of having a mechanism for them to speak with and support each other and to draw on broader networks and knowledge. To this end Ms Bennett advised the committee that, on the advice of the CEO of AHPRA, the CHF wrote to the Chair of the National Boards' Chairs Group to seek the capacity to bring the community representatives on national boards together to optimise their representation.[64]

1.2 The Department of Health and Ageing advised that board members are subject to a code of conduct and the National Law provides for a duty of confidentiality regarding protected information.[65]

Committee view

1.58 The committee understands the requirement to protect certain information but is concerned to ensure this does not hinder the ability of community members to communicate with each other and the general public, nor their ability to reach out to relevant organisations to tap into their knowledge and canvass their views.

1.59 The committee encourages AHPRA, through the Chair of the National Boards' Chair's Group, to facilitate the CHF's request.

Ministerial reserve powers

1.60 Concerns about the potential for political interference in decisions were once more raised with the committee.[66] As noted previously in paragraphs 1.16-1.18, the AMA again raised its concerns about the reserve powers of health ministers in relation to accreditation standards (section 11d of the National Law). The AMA acknowledged the change made to the National Law where health ministers will now first have to consider the potential effect on the quality and safety of health care before issuing directions in relation to new or amended accreditation standards for medical education and training. However, the AMA believes this change is not sufficient to protect the public interest in terms of accreditation standards for medical education and training. It suggested that, as the Federal Minister for Health and Ageing is a member of the Ministerial Council, Federal Parliament could require the minister to apply a public interest test when contributing to a decision of the Ministerial Council. The AMA recommended the inclusion of the following provision in the National Law:

> 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

64 Ms Carol Bennett, CHF, *Proof Committee Hansard*, 30 April 2010, p. 4. See also letter from Ms Bennett to Mr Glenn Ruscoe, dated 28 April 2010, available from the committee website.

65 Department of Health and Ageing, answers to questions taken on notice at the 30 April hearing.

66 The Royal Australasian College of Physicians, *Submission 6*, p. 1.

> 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.[67]

1.61 While noting some concern about the ministerial reserve powers, the RACGP acknowledged that there may be circumstances where such decisions are necessary in the interests of the community. It noted that it is therefore important that any such process is public and transparent.[68] The Australian Nursing Federation also supported a public and transparent process.[69]

1.62 The Consumers Health Forum supported the reserve powers to intervene should a situation require it, particularly as the Public Interest Assessor role was removed from Bill B.[70] It argued that the reserve power would provide:

> …an additional level of decision-making to safeguard consumers from any decisions that may impact on patient health and safety.[71]

Committee view

1.63 The committee notes that public interest underpins the establishment of the NRAS. Extensive consultation has been undertaken over a number of years and the initial draft legislation was substantially changed as a result of concerns raised about ministerial powers. When COAG agreed to establish a national scheme, the initial proposal was that all the accreditation standards were to be approved by the Ministerial Council, with only a more limited recommending role for the National Boards. As a result of concerns raised by health professional groups, the approval power was transferred to the National Boards and the Ministerial Council was given a more limited oversight role to intervene when specific public interest issues arise.

1.64 The committee notes that ministers do not have control over accreditation processes. The AHWMC agreed that the accreditation function will be independent of governments. Accreditation standards will be developed by the independent accrediting body or the accreditation committee of the board, where an external body has not been assigned the function. Accreditation of educational programs is a specialised process that is undertaken by experts in the fields. The accrediting body or committee will recommend to the board, in a transparent manner, the courses and training programs it has accredited and that it considers to have met the requirements

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67 Australian Medical Association, *Submission 3*, pp 3-4.

68 RACGP, *Submission 8*, p. 4.

69 Ms Julianne Bryce, Senior Federal Professional Officer, Australian Nursing Federation, *Proof Committee Hansard*, 30 April 2010, p. 11.

70 The CHF acknowledged the reasons given by the AHWMC for this: that the increased role of the state and territory health complaints bodies and the strengthened and formalised role of community members on national boards removed the need for the Public Interest Assessor role.

71 Consumers Health Forum, *Submission 9*, p. 3.

for registration. The final decision on whether the accreditation standards, courses and training programs are approved for the purposes of registration is the responsibility of the National Board.[72]

1.65 Ministerial Council control over the setting of accreditation standards is limited to the power to give direction in relation to a new or amended accreditation standard. Furthermore, the circumstances in which directions on standards can be issued are themselves limited. Such a direction can only be issued where the Ministerial Council considers that the new or amended accreditation standard will have a substantive and negative effect on the recruitment and supply of health practitioners.[73]

1.66 Ministers, when using this power, will first be required to consider the potential effect on quality and safety of health care. In addition, to ensure transparency, any direction and the reasons for the direction must be published.[74]

1.67 The committee notes that the Australian Health Ministers' Advisory Council concluded that this mechanism 'delivers the greatest net benefit to the community' as:

> …in general it does not involve an increase in the regulatory role of governments. The independent role of professional bodies in the accreditation process is maintained as the final decision on whether the accreditation standards are approved for the purposes of registration remains the responsibility of the national board for each profession. The national boards are best placed to approve accreditation standards that will apply to their profession. The limited scope of the reserve power of the Ministerial Council to issue directions on accreditation standards allows for an appropriate level of regulatory oversight in relation to matters that are rightly the concern of governments including the quality and safety of health care.[75]

1.68 As the public interest underpins this entire piece of legislation and is what guides ministers in their decision making, the committee believes it is unnecessary to include a provision in the legislation to apply a specific public interest test on this aspect.

Mandatory reporting exemptions

1.69 The National Law requires practitioners, employers and education providers to report 'notifiable conduct', as defined in section 140, to AHPRA. A practitioner is

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72 Australian Health Ministers' Advisory Council, *Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law*, 3 September 2009, pp 30-31.

73 Australian Health Ministers' Advisory Council, *Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law*, 3 September 2009, pp 30-31.

74 See Australian Health Workforce Ministerial Council Communiqué, 27 August 2009, p. 1.

75 Australian Health Ministers' Advisory Council, *Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law*, 3 September 2009, p. 31.

exempted from reporting in certain circumstances.[76] The AMA raised the need to exempt from the mandatory reporting requirements those doctors who are in a therapeutic relationship with other doctors. While it recognised that the Federal Parliament is limited in its ability to influence amendments to the National Law on this issue, the AMA recommended that the committee ask the Federal Minister for Health and Ageing to monitor the effect of the mandatory reporting provisions and report to the Federal Parliament annually.[77]

1.70 The RACGP also raised concerns about the mandatory reporting requirements, believing that they will have the opposite of the intended effect and recommended that they be reviewed or removed:

> …The legislation, as currently written, will cause medical and health practitioners to hide their impairments and professional issues from their colleagues, driving the issues underground and increasing, rather than decreasing, the risks to patients, the public, the practitioners themselves, and their colleagues.[78]

1.71 The committee notes the MBA has looked at this issue and reported:

> The Board is aware of the professions' concerns about the new mandatory reporting obligations required under the National Law. The Board has approved draft guidelines about mandatory reporting that provide guidance and explain more fully the obligations of health professionals. The Board will be consulting on the content of these guidelines during March and encourages everyone with an interest in this important issue to make a submission to the Board.[79]

1.72 The AHWMC believes that mandatory reporting of health practitioners will deliver a greater level of protection for the public:

> Ministers agreed that reportable conduct will include conduct that places the public at substantial risk of harm either through a physical or mental impairment affecting practice or a departure from accepted professional standards. Practitioners who are practising while under the influence of drugs or alcohol, or have engaged in sexual misconduct during practice must also be reported.[80]

1.73 Professor John Horvath, Principal Medical Consultant, Department of Health and Ageing, spoke to the committee on this aspect and advised:

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76 Department of Health and Ageing, answer to question taken on notice at the 30 April 2010 hearing.

77 Australian Medical Association, *Submission 3*, p. 4.

78 RACGP, *Submission 8*, p. 3.

79 Medical Board of Australia, Communiqué, 24 February 2010.

80 AHWMC Communiqué, 8 May 2009, p. 3.

> ...I am aware that there was significant concern expressed throughout the professions about this. However, due to a significant number of high-profile cases that we are all aware of that perhaps could have surfaced a lot earlier had there been a mandatory reporting, a number of states already had mandatory reporting in their legislation and it was very clear that state health ministers were not of a mind to dilute their public protection by removing that. There was a view of all ministers that this was an important public protection.[81]

1.3 Professor Horvath advised that there are conditions where it is recognised that mandatory reporting would not be appropriate and these have been taken into account either in the legislation or by regulation.[82] The Department of Health and Ageing advised that during April 2010 all National Boards undertook consultation on draft codes and guidelines for mandatory reporting and the final codes and guidelines will assist practitioners, employers and education providers to work with these requirements.[83]

Committee view

1.74 The committee accepts that the need for appropriate exemptions to mandatory reporting has been taken into consideration.

Improved feedback to organisations

1.75 The committee notes with disappointment a concern raised by several organisations regarding a lack of appropriate feedback following the consultations to establish NRAS. These organisations were engaged in consultation but, if an issue which was important to them was not ultimately included in the legislation, there appears to have been a lack of effective feedback and discussion about why that occurred. The committee notes that the consultation work was not undertaken by the department but by the implementation project team. It further notes that the issue has arisen throughout the process and may ultimately affect an organisation's trust in how the system will work.

1.76 However, the committee notes that the department appears willing to further engage with organisations with residual issues and encourages this to occur.[84] The committee also encourages the application of lessons learned during the establishment of NRAS to future consultation processes.

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81 Professor John Horvath, *Proof Committee Hansard*, 30 April 2010, p. 29.

82 Professor John Horvath, *Proof Committee Hansard*, 30 April 2010, p. 30.

83 Department of Health and Ageing, answer to question taken on notice at the 30 April 2010 hearing.

84 Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 26; Ms Maria Jolly, Department of Health and Ageing, *Proof Committee Hansard*, 30 April 2010, p. 28.

Conclusion

1.77 The committee recognises the time, effort and constructive engagement required by all stakeholders to establish the NRAS. The benefits of the scheme are clear: it will end duplication of effort, inconsistent standards and the red tape caused by multiple systems. It will improve mobility for the health workforce and contribute to improving the safety of the health system.

1.78 The committee is pleased to support this bill as part of the process of implementing the NRAS.

Recommendation 2

1.79 The committee recommends that the bill be passed.

Senator Claire Moore

Chair

May 2010