ACT DEPARTMENT OF HEALTH AND COMMUNITY CARE

NATIONAL COMPETITION POLICY

REVIEW OF

ACT

HEALTH PROFESSIONAL REGULATION

SEPTEMBER 1999

Preface

Persons who practice in the healing arts have long held privilege, enjoyed benefit and been placed in positions of trust by society. To a greater or lesser extent modern society has also sought to secure this regard through degrees of government regulation.

'For the last two hundred years the countries of Europe, as they have developed, have seen both total deregulation and the need for regulation of medical practitioners, and later nurses.

In the French Revolution (1789-1799), University licensing facilities for medical practitioners were abolished. The Revolution briefly embraced practice thrown open to all, both formally trained and irregular. A fee was required from anyone who wished to have a license to practice. Napoleon found it necessary to restore order and in 1803 instituted direct State Examination licensing of medical practitioners. This certified that they had four years of medical education and were qualified to practise anywhere in France and its territories. The system was adopted by all parts of the world adhering to the Napoleonic Code.

In Germany, the Government has long regulated medicine but in 1869 in both Germany and later Prussia, Bismark established "freedom of healing" which persisted up until the middle of the twentieth century. However the irregulars were not recognised by Government for issuing certificates, performing vaccinations, prescribing dangerous drugs or being physicians representing the Government in public health, hospitals, infant welfare, mental care, and aged and infirm and other roles which were stated in a medico-legal capacity.

The institution, in 1883, of medical insurance in Germany also required that public money being paid on behalf of the sick went to people who were suitably qualified.

In Britain, from about 1700 on practitioners were licensed by their respective colleges with the title and various group associations. In 1815, an Act of Parliament attempted to set standards for professional education in England and Wales, which ensured that a general practitioner would have undergone at least some academic and clinical training. In 1858, the Medical Act was passed providing a unified Medical Register for medical practitioners and ensuring that they alone would be eligible for public employment. It specified entry qualifications with the General Medical Council as an ethical legal watchdog with jurisdiction over malpractice. This ensured that when the National Insurance Act of 1911 and later the National Health Service was established in 1948, the Government was able to be confident that those practitioners they were paying on behalf of the public were, in fact, qualified to provide."[1]

[1] Dr T Walker (submission to the review) with acknowledgment to his source The Greatest Benefit to Mankind, Roy Porter, Harper Collins, 1997

The experience of modern history suggests an ongoing tension between a society's need to have a ready supply of health professionals regulated chiefly by market demand and concerns that health professionals have predictable and high standards of practice. This tension continues today and appears within the principles that underpin national competition policy. In particular this policy requires that -

"conduct with anti-competitive potential said to be in the public interest should be assessed by an appropriate transparent assessment process, with provision for review, to demonstrate the nature and incidence of the public cost and benefit claimed."

This report examines the legislative conduct requirements established with respect to ACT health professionals in order to identify both restrictions on competition and the costs and benefits of such restrictions. The report will further, in its conclusions, examine the contemporary relevance of the restrictions and recommend the restructure of legislative controls where their benefit is outweighed by their cost. While this review will explore the consequences of an unregulated market the anticipated outcome of this review process is legislation that operates in a more efficient and responsive manner.

Terms of Reference

The purpose of this review is to examine the health professional registration Acts with a view to weighing up the benefits of maintaining any anti-competitive provisions therein in line with the requirements of the Competition Principles Agreement. This review examines the case for reform of any legislative restrictions on competition contained in the legislation governing the registration and conduct of registered health professionals.

The review has regard to the relevant sections of the Competition Principles Agreement and makes use of material contained in guidelines published by the Commonwealth and ACT Government on regulatory impact statements and on conducting NCP legislative reviews. In particular the review has referred to the document **Guidelines for the Review of Regulation of the Professions under National Competition Policy** produced by the COAG Committee on Regulation Reform 1999. This document has been a particular reference in the development of a cost benefit analysis framework.

The review also has regard to the need for consumers to be confident in the choices they make about their health treatment from a range of clinically competent health professionals.

Date of Review

Commenced May 1999

Legislation

Medical Practitioners Act 1930
Nurses Act 1988
Dentists Act 1931
Chiropractors and Osteopaths Act 1983
Dental Technicians and Dental Prosthetists Registration Act 1988
Optometrists Act 1956
Pharmacy Act 1931
Physiotherapists Act 1977
Podiatrists Act 1994
Psychologists Act 1994

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Report Structure

This report is structured broadly along the lines of the of the Guidelines for the Review of Regulation of the Professions under National Competition Policy

Section 4. Background – outlines the scope of ACT health professional legislation, the perceived purpose of the legislation, and contemporary demands to assess the continuing benefit of the restrictions contained within the legislation.

Section 5. Health Professional Market in the ACT – overviews the market framework within which health professionals operate in the ACT, the contribution of health professional legislation to health market structure and the confluence of the legislation with other market regulation.

Section 6. Review Information – examines the objectives of the legislation, identifies the provisions within the legislation that assist the achievement of the objectives but which may also restrict competition and analyses the likely effects that these restrictions have on competition.

Section 7. – Analysis of the likely effect of the restrictions on competition arising from the statutory conduct requirements - assesses by distributional analysis the costs and benefits of the restrictions identified in the previous section.

Section 8. Alternative means for achieving public benefit - discusses alternate means to achieve the legislative objectives.

Section 9. Conclusions – brings together the issues and proposes those restrictions that should be maintained in the public benefit and those that should be removed or modified to reduce costs and improve competitiveness.

Background to Review

National Competition Policy and the Health Professions

The ACT's *Medical Practitioners Act 1930* is the oldest of a series of 11 ACT health professional registration Acts. These Acts, in a form pioneered by the Medical Practitioners Act, establish the qualification requirements, conduct standards and administrative arrangements for the registration of health professionals in the ACT. Only persons who have met the statutory requirements for ongoing registration may engage in the field of practice of a registered health professional or use the registered title of a health professional.

The ACT provides statutory protection for the practice of a registered health professional based on an understanding that;

- registration requirements are generally a close proxy for satisfactory performance and persons who have met the standards are more likely to provide an appropriately skilled and safe level of service;
- without the signals provided by registration the general public would otherwise have difficulty in their selection of an appropriate and competent provider, and
- epidemiological concerns require early and skilled intervention in order to avoid potentially serious population health outcomes.

The trade off between granting exclusive rights of practice in return for the abovementioned community protection has both costs and benefits. Costs are likely to be associated with the administration of a registration scheme and higher prices for services resulting from scarcity of supply and restrictions on market (competitive) conduct. Benefits accrue as a result of higher quality health services, their greater reliability, and the insulation of health services from some of the undesirable consequences of commercialisation.

While support for the statutory registration of health professionals may be concluded intuitively or even endorsed by the experience of history it is appropriate that a more rigorous exercise identify the net benefit of the legislation. The ACT is required to perform such a review under its obligations to National Competition Policy (NCP). The Competition Principles Agreement arising from NCP establishes that the ACT is required to review anti-competitive legislation and regulation with a view to removing unjustifiable restrictions on competition. Where restrictions remain they must be clearly demonstrated to be in the public interest.

The process of assessing the public interest requires a process of weighing up costs and benefits of the legislative restrictions to the community. Competition is to be implemented to the extent that the benefits that will be realised from competition outweigh the costs. It is recognised in the Competition Principles Agreement that where anti-competitive behaviour is acceptable to achieve a public good, there must be a transparent process for assessing the balance between benefit and cost, and the behaviour must be subject to review.

While the Competition Principles Agreement does not specify how a review will be conducted it does indicate that a review should address the following - *clarify what the legislation is trying to achieve; identify the nature of any restrictions on competition; analyse the effects these restrictions have on the whole of the community; assess the benefits and costs of the restrictions; and consider whether or not there are alternative approaches to achieving the legislative objectives.*

This review incorporates the above broad methodology.

Consultation

This review has its antecedents in a 1998 legislative audit conducted on behalf of the Department by Pendragon Consulting. This audit independently reviewed all legislation administered by the Department of Health and Community Care and identified legislative provisions that were to be further reviewed under obligations to National Competition Policy. The health professional registration Acts were identified as legislation that contained anti-competitive provisions and required review.

This review formally commenced in May 1999 with the targeted public release of a discussion paper titled **Review of Health Professional Registration Legislation in the ACT**. This discussion paper was prepared as a broad critique of the existing health legislation. Within the paper issues related to the anti-competitiveness of provisions within the legislation and the general efficiency and effectiveness of the legislation were identified. The paper further proposed a preferred Departmental position in relation to the identified issues.

The Discussion paper was promoted through advertisement in The Canberra Times and by direct distribution. A total of 198 hardcopies of the report were issues and the Internet posting of the report registered 260 "visitors". The report was further promoted by representation made directly to health professional and consumer organisations.

There were 43 formal submissions to the Discussion Paper. All persons and groups providing submissions were given an abstracted version of the collective submissions for their reference.

Organisations and individuals who responded to the Discussion Paper were further engaged in consultations through the distribution, in December 1999, of a document titled a **Draft Legislative Framework for a Health Professional Registration Act**. This document was prepared and circulated in order that interested parties might review how, as a result of the previous discussions and consultations, a new model of health professional regulation may operate.

The circulation of the legislative framework document resulted in a further 32 formal submissions being received by the Department.

Documents prepared and published to support this analysis are considered to form part of the overall regulatory review.

5
Health Professional Market in the ACT

5.1 Market structure

The health professional market in the ACT is composed of both registered and non-registered health professionals. There are approximately 7450 registered health professionals and an unknown number of non-registered health professionals.

Together, Territory health professionals service a consumer population that is largely drawn from the ACT and near southeastern region of NSW. Health services provided, range through specialty major tertiary trauma services, to general primary health care services and secondary support services involving rehabilitation and ill health prevention. ACT health professionals may work within the public or private sectors, be self employed, employed within a small practice or employed by government in a health facility, policy department or teaching/research facility.

The ACT health professional market is similar to health professional markets across Australia. The registered health professions are typically drawn from the traditional western health disciplines, require the achievement of tertiary level qualifications, involve treatments that have the potential to lead to a serious and non-reversible health outcome for consumers, and are those services that are most commonly engaged by the public health system. The registered health professions also have a core body of knowledge that is generally unique to each individual occupation. The non-registered professions are represented by occupations that either provide a support service to other health professionals, have a low potential harm classification and/or are drawn from alternative and/or non-western health disciplines. Occupations such as radiographers, social workers, massage practitioners and traditional Chinese medicine practitioners are representative of non-registered health professions. With only a few exceptions these professions have typically not been regarded as "mainstream" nor as ones that pose high risks of harm to patients.

While the 'body of knowledge' of individual health professions, both regulated and unregulated, is largely separate, consumers have a choice, particularly in terms of non-acute services, from treatments that may substitute for each other. A health consumer suffering a muscular injury may, for example, seek treatments offered by a range of registered professions including medicine, physiotherapy or chiropractic, or treatment by non-registered professions including treatment from a herbalist, an acupuncturist or masseur.

In summary the health professional market services a distinct local purchasing population and provides services that range from acute to remedial and preventative care. The market comprises a range of professions both registered and non-registered with at least each registered profession having multiple members. The market can be further characterised by competition between like professionals and in certain circumstances competition between substitutable services.

5.2 Influence of health professional legislation on market structure.

The exiting health professional registration legislation does much to shape the current market structure. As is discussed in detail later in this report the current legislation controls entry to the registered professions, and the professional and to some extent business conduct of a registered professional. In addition however, the legislation also actively determines who may provide certain health services. Typically the health professional Acts make it illegal for a non-registered health professional to use the title of a registered health professional or to provide the services offered by a registered health profession. Accordingly a person who is similarly trained but not registered or a person who's training is less than that required for registration may not offer to provide the health services of a registered professional. One outcome of this prohibition is that capacity to provide or choose substitute services is limited. An orthoptist may not for example provide the diagnostic/prescription service of an optometrist, nor may an aboriginal dental worker provide the services of a dental hygienist. In such circumstances substitution is not permitted even though the consumer may be prepared to accept a lower technical quality of services in return for more appropriate access and price considerations.

While the ACT's health professional legislation has restrictions on entry, in practical terms most ACT health professionals are initially registered without direct reference to such requirements. With the exception of the nursing profession, where new graduates may be training in the ACT, the ACT initially registers most health professionals through the operation of the *Mutual Recognition Act* 1992 (Cth) or the *Trans Tasman Mutual Recognition Agreement.* Health professionals registered in a jurisdiction participating in the latter agreement may generally expect, on application, to be 'automatically ' registered in the ACT. The ACT effectively adopts the requirements for registration that are established within either other individual jurisdictions or as are endorsed on a national basis.

5.3 Health professional legislation – inter-relationship with other market regulation and agreements.

While the focus of the ACT's health professional legislation is on the registration of ACT health professionals the legislation has over time become linked with a raft of other community protection/enforcement legislation and financial arrangements. In many cases the ACT health professional legislation is used to certify the service standards and standing of health professionals. For example-

- poisons and drugs legislation, relies on the health registration Acts to attest to the competence of certain health professionals to prescribe and dispense potentially harmful drugs and poisons;
- information accepted in court proceedings related to expert health opinion often draws credibility from a health professional's registration status;
- national health funding, health insurance, and health taxation arrangements all rely on there being a formal legislative system of health professional registration; and
- the ease of interstate movement of health professionals is based on an acceptance and recognition of the standards of registration within individual jurisdictions. Where registration standards within one jurisdiction were substantially different

to other jurisdictions the policy principles of mutual recognition would cease to apply.

The inter-relatedness of the various legislation and arrangements results in a complex policy environment. Changes in one area of policy need to be evaluated not just for their immediate impact but for potential repercussions in other areas. The broad impacts themselves may result in higher overall costs than the benefit derived from the immediate reform.

6
Review Information

6.1 The objectives and restrictive provisions of the health professional registration Acts

The objectives of the health professional registration Acts are not directly specified within the existing legislation. The objectives may however be reasonably inferred from the operation of other like legislation and from an interpretation of the outcomes of the major competitive restrictions that operate within the legislation.

Occupational registration in general is held to operate to counter market failure. That is failure of the open market to provide the right quality of services at the right price without undue risk of loss to the consumer. Loss could result from costs involved in locating a competent service provider (transaction costs), costs to parties not involved in a service transaction (negative spillovers) and loss or abuse as a result of the disparity of information (information asymmetry) between the supplier of services and the consumer of services. It is appropriate to prescribe therefore that health professional legislation is about protecting the public from loss in their transactions with health professionals.

The review of restrictions that are contained within the health professional legislation supports the above assessment. The potential for loss is addressed by the following category of restrictions.

- restriction on who may practice in the professions (Entry Standards),
- restrictions on professional conduct including business activities through the establishment and administration of fitness to practice standards and related sanctions (Conduct Standards), and
- the provision of vested powers to regulatory Boards such that through their administration of the Act they have a significant influence on the practice of health professions and the conduct of business by health professionals (Regulatory Boards).

It may be reasonably inferred that the statutory registration of health professionals in the Territory has the objective of protecting the public by ensuring that persons practicing as health professionals have met minimum qualification requirements and that they evidence initial and ongoing fitness to practice standards.

6.2 Entry Standards

All health registration Acts contain provisions that require health professionals within the professions to be registered. The Acts establish a system whereby prospective applicants must meet certain requirements to be registered. These requirements are summarised in Table 1.

Table 1. Current entry standards (where 'x' indicates the presence of the standard in the legislation relating to the particular health profession)

Legislative standard	MP	Opt	Den	Psy	Pod	Phy	Pha	Nur	Vet	C/ O	DT/ DP
Sufficient mental capacity, physical capacity and skill	x	x	x	x	x	x	x	x	x	x	
Competency and good character	x	x		x	x	x	x	x	x	x	
Sufficient communication skills and adequate command of the English language	x	x	x	x	x	x	x	x	x	x	x
Not having been convicted of an offence	x	x	x	x	x	x	x	x	x	x	
Fit to practice in the profession	x	x	x	x	x	x	x	x	x	x	x
Not removed from a foreign register for conduct reasons	x	x	x	x	x	x	x	x	x	x	
Not having engaged in conduct that would bring the profession into disrepute			x								
Qualifications	x	x	x	x	x	x	x	x	x	x	x
Pre-registration training	x			x			x				
Mutual recognition	x	x	x	x	x	x	x	x	x	x	x
Fee requirements	x	x	x	x	x	x	x	x	x	x	x

- In support of the entry standards all Acts make it an offence for unregistered persons to practice in the profession or for such persons to use the title of a registered health professional.
- The entry requirements themselves may be summarised as relating to restrictions concerning fitness to practice, qualifications, fee requirements, mutual recognition, and non-registered persons not to practice. The legislative requirements relating to these restrictions are further detailed at **Appendix 1**.

6.2.1 Profession specific entry requirements

In addition to the more generalised entry requirements profession specific entry restrictions exist within two Acts as follows-

	Entry Requirements
DT&DP	Possession of professional indemnity insurance
	Domiciled in Australia
	Company not restricted by its memorandum of association.
Nursing	Refresher course requirements if applicant has not practiced in the profession for the past 5 years

6.2.2 Likely Effects of the restriction on competition arising from the statutory entry requirement

In specifying the entry requirements for unconditionally registration as a health professional the Acts are likely to create a barrier to entry for persons and businesses who may seek to provide a health service of the kind supplied by a registered health professional but who may not possess one or more of the requirements or possesses them below a standard considered appropriate by the Boards.

These requirements have an effect of restricting the market supply of persons who may practice as health professionals and preserve the economic benefits of being a health professional to specific occupational groups.

Within a market place where statutory requirements restrict entry there is capacity for services to be provided inefficiently, for employment/innovation opportunities to be curtailed and for an artificially high price for services to be passed on to consumers.

In a market where no restrictions applied persons with and without training would compete for market share. Theoretically survival in the market would be determined by consumer acceptance of the price and quality offered by the provider. Consumers would however need to be well informed in their health purchasing so as not to make an unsafe or compromised purchasing decision. There may also need to be alternate health professional accreditation schemes developed to meet the needs of related regulatory requirements.

6.3 Conduct Standards

Persons registered under the health professional Acts have their professional conduct and business activities restricted by the legislation. The legislation achieves this control by establishing disciplinary grounds as standards of conduct to be exercised by registered health professionals.

6.3.1 Disciplinary conduct standards

The health registration Acts establish a number of grounds where individual Boards may invoke disciplinary action against registered members. The most common grounds are set out in Table 2.

Table 2. Grounds for taking disciplinary action.

	MP	Opt	Den	Psy	Pod	Phy	Pha	Nur	Vet	C/O	DT DP
Registration by fraud or misrepresentation	x	x	x	x	x	x	x	x	x	x	x
Withdrawal of professional qualifications	x	x	x	x	x	x	x	x	x	x	
Contravening conditions	x	x	x	x	x	x	x	x	x	x	
Conviction of an offence	x	x	x	x	x	x	x	x	x	x	x
Habitual drunkenness or addiction to drugs	x	x	x	x	x	x	x	x	x	x	x
Not competent/fit	x	x	x	x	x	x	x	x	x	x	x
Canvassing / advertising other than permitted	x	x	x					x	x		
Improper or unethical conduct	x	x	x	x	x	x	x	x	x	x	
Failure to exercise adequate judgement	x	x	x	x	x	x	x	x	x	x	
Practising when registration suspended	x	x	x	x	x	x	x	x	x	x	
Bringing the profession into disrepute/ improper unethical conduct	x	x	x	x	x	x	x	x	x	x	
Permitting non registered practice	x	x									

6.3.2 Profession specific disciplinary conduct standards

In addition to general disciplinary grounds some Acts have specific conduct exclusions as set out in Table 3.

Table 3. Profession specific disciplinary conduct standards

	Disciplinary standards
Podiatry and Medical Practice	Advertising by a body corporate to provide a health service whether through a health professional or not.
DT&DP	Not maintaining professional indemnity insurance
Medical Practitioner and Optometrist	Permitting an assistant ...who is not registered to treat a patient
Medical Practitioner	Conduct that results in a conviction against the *Health Insurance Act.*
	Refusing or failing, without reasonable excuse to attend...where a person is in urgent need of attention by a medical practitioner.
	Using a certificate, diploma, membership, degree, licence, letters, testimonial or other title, status, document, or description in relation to him or herself or in the practice of medicine, other than (one) either recorded in the register or used by the practitioner before the commencement of the Act.
Pharmacy	A Pharmacist may not (a)keep or maintain a shop.....unless while open for business (it is) constantly his or her control....or some other registered pharmacist as an assistant or agent.... (b) permit any person , other than a bona fide assistant or apprentice ...under his or her actual supervision...to sell or supply medicines...or dispense prescriptions. (c) carry on business except under the actual personal supervision ....of a registered pharmacist. (d) practice pharmacy except in the name under which he or she is registered as a pharmacist. (f) give medical advice except in his or her place of business and (in certain situations) (g) allow his or her name to be used....at any premises where there is not a registered pharmacist in daily attendance. (h) aid or assist any person other than a registered pharmacist to practice pharmacy....
	Providing certain medicines not prescribed by a doctor.
	Not maintaining a prescription register.
Dental Therapists	Dental therapists may only be employed as a public servant, work under the direction and control of a dentist employed by the Territory, and perform certain approved dental

	procedures on persons who are 16 years or younger.
Dental Hygienists	Dental Hygienists shall not perform certain specified procedures except under the direction and control of a registered dentist.
Optometrists	A person other than a registered optometrist shall not sell spectacles or contact lenses other than spectacles or contact lenses dispensed in accordance with a prescription written by a medical practitioner or by a registered optometrist

6.3.3 Likely effect of the restriction on competition arising from the statutory conduct requirements and sanctions

Disciplinary conduct standards and allied sanctions may act to restrict the competitive conduct of health professionals and as a result reduce economic outcomes for health professionals and consumers alike. This potential derives both from the nature of the provisions themselves and their potential application by the regulatory Boards.

Conduct standards normally demand compliance and a uniform response from registered health professionals. Those acting outside the conduct requirements are however liable to face disciplinary action and potentially to have their capacity to work in their profession restricted and in some cases to be removed from engaging in a health professional. Restrictions on the capacity to work removes a health professional from full participation in the workforce leading to an outcome of less open market competition.

The anti-competitive power of the restrictions however more commonly arises from their observance rather than their enforcement. The forecast of possible sanctions is generally sufficient for both health professionals and the general population to moderate their conduct even to the extent of foregoing potential competitive benefit.

Conduct provisions that restrict specific activities have a clear potential impact on competition as follows;

- Where unregistered persons, are unable to purchase or otherwise manage health practices the competitive effects of such provisions may include limitations on economies of scale and therefore price benefits or limitations on innovation from different ownership structures or capabilities.
- Advertising restrictions may control how practises or products may be promoted and otherwise distinguished and chosen by the consumer. Along with the resultant limitations on the information base for consumers on which to make their health purchasing decisions there also may be an impact of restricting new entrants from establishing access to markets and otherwise competing for business.

Where conduct standards are less well defined such as prohibitions on ‘unethical behaviour’ and ‘improper conduct’ the likely results are that either–

- Health professionals will engage in conservative business conduct out of concern that their conduct not breach unspecified conduct requirements; and/or
- The regulatory bodies may interpret the broad conduct requirements to control business conduct.

Outcome's such as the above are likely to preclude innovation and dynamism, encourage conservative business management, maintain inefficient operations and generally further the status quo. The outcomes for consumers is also likely to be that of reduced choice arising from the non-availability of comparative information on competitors arising from price or non price (quality) signals such as access, convenience and service. Consumers are also likely to have reduced access to information that would allow them to establish some parity in any health purchasing contract.

Without disciplinary conduct standards health professionals would be free to conduct and market their services within the parameters applying to most other businesses. Survival in the market would be linked to competitiveness and the exercise of consumer choice. Health consumers may in these circumstances be better informed and more able to exercise control of their health care treatment.

The risk of unregulated health professional conduct is that health consumers, particularly those least powerful and most vulnerable may be subject to abuse from an unprincipled health provider. A market driven health workforce may also be more prone to manipulate demand, particularly through promoting unfounded expectations and consumer anxiety. Existing market or legal mechanisms to sanction an unscrupulous or incompetent provider are likely to be to slow to discover and avoid misadventure and other tragic risk.

6.4 Board Regulatory Structures

Health Boards perform a central role in the administration and enforcement of the regulatory framework established by the health professional Acts.

Such Boards are empowered by the Acts to undertake the following major activities;

- Recognise appropriate qualifications and fitness for registration within the registered professions;
- Register health professionals under appropriate terms and maintain a "register";
- Scrutinise the conduct of registered professionals; and
- Inquire and adjudicate upon complaints against registered health professionals.

While Boards are charged with the above responsibilities they have also assumed roles in relation to further directing the professions and interpreting the Acts through the issue of board endorsed guidelines.

The core membership of Boards is drawn from either elected or appointed members of the regulated profession. In some instances Boards may have one community member. While Boards are accountable to government in practice governments are removed, from Board day to day decision making, from contesting board deliberations or from reviewing the overall performance of Boards. Boards are also not bound to

open their deliberations to public scrutiny although the outcome of their decision making maybe appealed within other public jurisdictions.

6.4.1 Likely effect of the restriction on competition arising from the board regulatory structures

The role of Boards is essentially to self regulate with the support of statute. The regulation overseen by Boards confers on them rights to oversight, who enters the professional market, conduct within that market and authority in certain circumstances to restrict or prohibit participation in the market. The scope of control of Boards is such that there is potential for a conflict of interest to arise and for Boards to make decisions or avoid making decisions that have impacts on the health professional market. This market is generally one they themselves compete in. Apart from their effect on direct market structure and conduct there is also potential for Boards to influence the information upon which consumers rely in their health purchasing decisions. Boards may also seek to actively guard the scope of practice of their profession and to launch action where another profession seeks to participate in their market domain.

Without Boards the legislation would either not be administered, would need to develop an alternate compliance methodology eg self administration, or there would be a need to develop an alternative regulatory body. Potentially any alternative body might have less professional representation and so be less open to claims of compromise. The body might however need to purchase professional advice and expend considerable resources in achieving professional support and compliance.

Analysis of the likely effect of the restrictions on competition arising from the legislative requirements

For each area of restriction there are costs and benefits to the regulated professions, to the individual consumer and to the community. The following discussion is to consider whether the benefits of the legislative restrictions to the public as a whole outweigh their costs and whether there are alternative approaches that would achieve the same objectives.

7.1 Method of Evaluation

The most comprehensive method for evaluating the anti-competitive effect of legislation is through a cost / benefit analysis. Cost and benefit analysis of regulation is most clearly demonstrated where it is possible to ascribe a specific market value to each restrictive provision (ie a restrictive provision has $*x* benefit and $*y* cost). Within occupational regulation however it is difficult to quantify the costs and benefits of restrictions, particularly where the outcomes sought from the legislation are largely qualitative (eg. public protection). While it is possible for example to identify a general benefit to the community by regulation that engenders security and confidence in transactions with health professionals it is another matter to prescribe a value to this community benefit. Concurrently the risks inherent in a cost benefit approach to occupational registration are that some important costs and benefits may not be measurable and hence may be given less weight in any analysis.

While there are major difficulties in completing a full-cost computation of cost and benefit in health professional legislation it is possible to complete a distributional benefit-cost analysis. Under this form of analysis benefit information and cost information are compared in order to assess the significance of the restrictions. As further analysis, risk information may also be used to inform the overall merits of the provision in the public interest.

As an outcome of the above approach an assessment may be made as to whether the benefits and risks that the restrictions are intended to address are of a significant magnitude to the exposed population compared to costs and other risks (eg economic effects of loss of competition). For this review factors that may direct the assessment are the known potential for tragic risk outcomes given the nature of health services. In terms of the health industry the judgement that needs to be made is do the current legislative controls offer a net public benefit over the alternative of full deregulation. Regulation may be anti-competitive where it provides a net public benefit.

Following the above assessment a further assessment needs to be completed of the overall-

- whether the regulation is the most effective tool available to provide the benefit; and
- whether there is an alternative use of available resources which would result in greater overall benefit to the community.

Benefit and Cost of Restrictions

Type of restriction	Who benefits /Who bears the Costs	Value of benefit / Risk analysis	What Costs
Entry Restrictions	Health Professional	• Less competition through reduction of potential suppliers. • Exclusive use of title. • Control of scope of practice. • Less price competition. • Less promotion costs. • Capacity to charge higher fees for services.	• Cost of obtaining qualifications (associated with tertiary study of between 3-5 years, supervised training and foregone income) • Registration and re-registration fees (note the average ACT fee of $103.p.a. has a negligible impact on costs and service price) • Reduced incentive to innovate and improve efficiency.
	Consumer	• Assurance that minimum competence and quality standards have been met. • Proxy for information asymmetry problems where the consumer otherwise lacks familiarity and knowledge parity in their assessment of the quality and adequacy of services. • Reduced search costs for provider with the right skills, price and quality mix. • Reduced costs from inappropriate treatment choice.	• Reduced access to an unrestricted range of providers. • Deterred from entry to the market due to costs of obtaining qualifications. • High tertiary entry requirements may restrict entry to persons who although having lower than required tertiary entry scores are otherwise suited to health professional life. • Risk of denial of access to services as a result of their high price.

	Community as a whole	• Enhanced health and productivity. • Avoidance of harm. • Economic benefits from healthier workforce. • Reduced risks of externalities and negative spillovers eg from the spread of disease. • Reduced costs associated with malpractice • Efficiency through using legislative title as a surrogate for individual certification schemes in a range of additional policy areas.	• Higher price for services as providers recoup their training and fee costs. • Premium service prices associated with exclusive supply arrangements associated with restricted title and scope of practice. • Restriction on who can compete for market access. • Restricted supply of services / limited choice, because of deterrence effect, and restrictions on the substitution of services. • Cost of providing tertiary level training • Professional structures restrict innovation and substitution within health provider services. • Administration costs of maintaining regulatory structures (note: with the exception of legal costs all other costs are self funded from fees) • Limited parameters within which regulatory discretion might be exercised

Type of restriction	Who benefits / Who bears the cost	Value of benefit / Risk analysis	What Costs
Conduct Standards – Professional	Health Professional	• Maintains the reputation and public confidence in the profession as a whole. • May restrict the supply of competing professionals.	• Contribution to disciplinary processes through fee levels. • Possible restrictions on practice /removal from practice as a health professional as a result of a breach of standards matter. • Conservative professional conduct as a result of poorly defined standards.
	Consumers	• Assurance that professionals who are not competent or not fit have been restricted in their practice or prohibited from practice. • Reduced risk associated with information imbalance.(particularly uninformed choice, protection from persons who have misrepresented their professional standards). • Provides redress opportunities for service complaints about quality and price. • Protects from substandard treatment, reduced risk of injury, illness or fatality.	• Costs of action on standards may be passed on as in higher fees for services. (minimal impact)

	Community	• Minimises negative spillover effects and other flow on effects/costs of malpractice.	• Costs associated with supporting a health complaint infrastructure. • Reduced choice associated with practitioners being reluctant to engage in practice innovations. • Lack of participation in standard setting and enforcement. • Risks that standards enforcement could be used to reduce competitive conduct.

Type of restriction	Who benefits / Who bears the cost	Value of benefit / Risk analysis	What Cost
Conduct Standards – Business			
Restrictions on advertising	Health Professionals	• Reduced costs associated with promotion and competition. • Maintains high fees.	• Restrictions on how health professionals can market their skills to the purchasing community. • Limitations on new providers informing potential customers on the availability of their services. • Limited commercial flexibility
	Consumer	• Protection from the health and financial consequences of false, misleading, exaggerated and unsubstantiated advertising. • Choice of provider less influenced by factors other than quality. • Reduced professional costs associated with recouping promotional expenditure.	• Lack of information limits consumers capacity to make informed choices about providers based on price, quality, risks etc. • Lack of information to differentiate poor quality providers. • Higher price for services.
	Community as a whole	• Reduced wastage from broad scale advertising • Advertising that is high on promotion	• Costs involved with the continued supply of inefficient and incompetent providers.

		and low on information may hinder health and safety	• Costs associated with monitoring the restrictions. • Duplication with other regulatory measures.
-Possession of PI insurance cover	Dental Prosthetists	• Protection of business viability in the case of a claim.	• Cost of maintaining indemnity insurance. • Uncapped awards placing increasing pressure on premiums
	Consumer	• Surety of compensation in the case of a successful negligence claim.	• Higher costs for services as a result of on passing premium costs.
	Community as a whole	• Protection from direct costs associated with negligent care.	• Costs of monitoring compliance (minimal–as compliance structures are currently self funded.) • Lack of evidence that possession of PI insurance contributes directly to the protective intent of the legislation
-Restrictions on practice	Dental Hygienists and Dental Therapists	• Provides that these dental auxiliaries may practice within the boundaries of their qualifications and training. • Limits the demands of an employer for the auxiliary to provide care beyond their skill level.	• Restricted capacity to engage in business

-Restrictions on prescribing spectacles and contact lenses	Consumer	• Potentially reduced risks and costs from selection of inappropriately trained provider.	• Reduced provider choice.
	Community as a whole	• Minimises the flow on effects of potential misadventure. • Provides accessible services within the public sector (dental therapists)	• Reduced innovation in service delivery. • Potentially increased dental disease as consumers unable to afford the cost of established dental providers.
	Optometrists	• Limits competition.	• Costs associated with attaining qualifications and maintaining registration.
	Potential provider		• Restricted from entering prescribing market.
	Consumer	• Assurance that person prescribing has a high level of qualification in eye physiology, eye disease and diagnostic assessment. • Reduced health and financial cost associated with inappropriate prescribing.	• Restricted choice of provider. • Higher cost of services (note most services bulk billed and the total cost is not directly met by the provider)
	Community as a whole	• Minimises flow on effect of misadventure	• May support the maintenance of inefficient and incompetent providers. (Note considerable competition exists within the optometry industry)

Type of restriction	Who benefits /Who bears the Cost	Value of benefit / Risk analysis	What Cost
Regulatory Boards	Provider	• Peer level understanding and judgement in relation to the interpretation and application of legislation including standard of practice matters. • Low fee costs associated with self regulation as compared to a more external regulatory authority. • Preservation of professional interests.	• Fee costs associated with maintaining the Boards. • Cost of meeting requirements applied by the Boards.
	Consumer	• Confidence that decision making will preserve standards and maintain basic competency levels. • Costs of administering the schemes of regulation mostly met by the professions and not through appreciably higher service fees.	• Restriction on service choice as provider innovation is not encouraged. • Limited information provided by Boards on which consumers may base purchasing decisions.
	Community as a whole	• Confidence between the regulatory authority and the professions encourages compliance with legislative standards. • Low cost option for maintaining and oversighting standards. • Standards for good health practice	• Board decisions may be taken to minimise impact on the profession as a whole rather than purely in the public interest. • Costs associated with potential conflict between the public interest and professional interest.

		administered in the public interest.	• Reduced public confidence in the independence of decision making. • Cost of operating and alternate regulatory body.

8

ALTERNATIVE MEANS OF ACHIEVING PUBLIC BENEFIT

The current model of regulatory control of the health professional market place is not the only possible alternative to achieving a level of consumer protection and confidence in their health care transactions. Other options exist and may operate on their own, in combination or in conjunction with a licensing system. These include;

8.1 Deregulation

The health professions could be deregulated entirely leaving market forces to select out providers who have the right price and quality mix of services to meet consumer needs. Providers themselves could support market forces by promotion and the development innovative structures to attract market share.

Where unsatisfactory or unsafe health services were to be received in a deregulated market the community would still have recourse to redress through general legislation, common law, and the private information market. These include access to or support provided by-

- Health complaints law and related conciliation services;
- Advertising and unsafe goods/fair trading legislation, allowing prosecution of persons who falsely describe, misrepresent or promote goods or competence;
- Consumer action through courts in relation to compensation for damages or injury suffered as a result of unsatisfactory services by a health professional;
- Consumer advocate groups and media systems targeting information and other power imbalances between consumers and health providers; and
- Health insurance schemes accrediting or otherwise certifying the competence of health providers.

There are however a number of factors that suggest that complete deregulation is not ideal in the current market system. Such factors include,

- Unsatisfactory transactions with a health professional do not only place the consumer at risk of direct economic loss but also at risk of injury, disability or even loss of life;
- Consumer protection legislation may be unresponsive to emergency situations where action to prohibit unsafe practices requires confirmation through judicial process;
- Health complaints legislation relies on access to health professional regulatory systems to intercede in questions of health professional conduct and competence;
- The interests of the consumer and the health provider may not always be the same with consumers being disadvantaged by their lack of equivalent knowledge;

- Providers with less than optimum qualifications may permit health conditions to develop that are of greater economic burden than the existing costs of maintaining a regulated market;
- Providers with unsatisfactory skills may remain in the marketplace and target their services, in particular, towards disadvantaged groups;
- The health and financial costs of misadventure or epidemic are borne not only by the individual but by the community at large and these costs could be expected to increase significantly if inadequately trained and experienced health professionals were permitted to operate in the market.

Deregulation offers opportunity for market forces to select appropriate providers. It would also work to encourage private regulatory systems to take a much more active and innovative interest in the regulation of price and quality issues within the health market place. Deregulation would however place the health of individuals and the community within systems that are disparate, sometimes characterised by strong self interest and unresponsiveness. Costs from misadventure are also likely to quickly rise beyond that currently borne by the community through the health professional regulation process. While there is opportunity to develop and draw on systems that provide privately sponsored health protection full deregulation is unlikely to ever provide sufficient protection for the community.

8.2 Self Regulation by the Health Professions

Professional self-regulation without regulatory support offers some level of control over the conduct and performance of health professionals. Many of the health professional associations already have ethical, conduct and professional development requirements for accredited membership. In some conduct and performance areas the requirements established by the professional associations are in advance of existing legislative registration requirements. Professional associations also offer superior flexibility in responding to emerging issues and there appears to be ready industry compliance with association requirements. Self regulation may additionally reduce the need for and the cost to government of resources spent administering a regulatory system.

Self-regulation as a stand alone quality and price gatekeeper within the health professional market is however unlikely to ever offer the same level of community protection as that provided by existing statutory registration systems. The weakness of self –regulation schemes include-

- membership of professional associations is not compulsory;
- associations may deny or restrict membership to those who do not maintain required levels of performance, but they can not otherwise discipline or restrict unsatisfactory operators in the health market place;
- some professions are characterised by fragmented professional associations;
- professional associations primarily represent the interests of members and these interests may not be the same as the community's interest;
- professional associations may be used to promote anti-competitive conduct, including barriers to entry; and

- health professional associations have not traditionally undertaken a consumer advocate or inquiry role in complaints processes nor would they be seen as independent in such processes.

Self regulation on its own is not an adequate response to the health professional and community market imbalances. The overall approach is considered to involve a greater risk to the public of serious harm or injury when compared to risks from the current regulatory approach. Some professional association standards, such as for ongoing professional development, may however be increasingly looked upon as a substitute for a regulatory requirement.

8.3 Negative Licensing Scheme

Under a negative licensing scheme health professionals would not be screened before starting to practice. Effectively there would be no initial formal test of competency. Under such a scheme however the government retains the authority to withdraw a health professional's right to practise if the person subsequently fails to meet minimum professional standards of work and conduct. Under a negative licensing scheme for health professionals there would be-

- Low compliance and administration costs as a result of health professionals having lower participation costs and government encountering less up front costs in administrating such a scheme. (noting that government would still need to develop regulation and have a system of compliance monitoring);
- Lower entry barriers and the removal of dominant industry players from coercive control of market entry;
- Possible increases in health professional numbers with resultant pressure for competitive pricing;
- Capacity to remove a license may be a sufficient threat to maintain service quality;
- Non-performing health professionals can be removed from the market.

The potential disadvantages of a negative licensing scheme include-

- The absence of an initial screening system may permit persons to initially provide health services that are unsatisfactory and this may result in loss to individuals and the community;
- Some health professionals may be able to operate undetected in the market place and cause considerable damage;
- Such schemes are not proactive and they provide inadequate means for early intervention or the ready enhancement of standards;
- Alternate enforcement and monitoring activities may need to be established and supported.

While negative licensing offers a less invasive system of regulation its major deficit is in not providing an intervention framework until after a complaint has been made. Without an approach involving initial certification there would be substantial risks of loss before incompetent or unscrupulous health care providers could be identified and

brought to judgement. Community demands and government obligations are unlikely to support this level of change to regulation. In addition should there be a move by the ACT to introduce a negative licensing system for health professionals this would place the ACT at odds with all other State and Territory jurisdictions. One direct outcome of such a change would be the loss of benefit of ACT health professionals from mutual recognition arrangements. Further disruption and risk would also occur to existing systems that rely on initial and ongoing certification of health professionals. These include health care, payment and insurance systems, population health legislation including drugs and poisons law, and various pieces of legislation that refers to certification etc by licensed/registered health professionals.

9

Conclusions and Recommendations – Existing Legislation

This Review has identified a number of provisions within the existing legislation that may act as restraints on competition. These restraints appear throughout the legislation and are similarly expressed across all 11 health professional Acts.

The anti-competitive provisions have been designed to –

- re-dress a perceived imbalance of knowledge, and thereby market power between the consumer and health provider (information asymmetry);
- provide community protection from tragic risks associated with the consequences of inadequate health care (negative spillovers); and
- regulate the influences of commercial conduct on professional services.

Within the legislation the above objectives are achieved by having in place restrictions as follows –

- **Restrictions on entry** – The aim of such restrictions is to stop inadequately trained or otherwise potentially problem health professionals from entering the market, or in some cases removing such persons from the market.
- **Restrictions on conduct through professional standards –** These restrictions seek to maintain the quality of heath professional services.
- **Restrictions on business –** These restrictions limit such areas as advertising in order to suppress price competition or other commercial decisions that may be made to the detriment of quality and professional rigour.
- **Restrictions or potential restrictions arising from the administration of the legislation by regulatory Boards -** are charged with enforcing and interpreting the legislation. Boards thereby have a broad scope of influence in relation to the market conduct of health professionals.

The restrictions while aimed at providing the above benefits also result in costs. Such costs relate to

- **Restricted supply of services** - resulting in reduced consumer choice, reduced access and reduced participation.
- **Higher price for services** - lack of competition enables a premium price to be charged for services.
- **Information imbalances** – consumers have reduced information on which to base their health purchasing decisions.
- **Enforcement costs** – wherein the costs of administering the requirements of the legislation may be passed back to the consumer.

This Review has discussed a number of alternatives means to achieve the desired legislative outcome of consumer/community protection. The alternative approaches reviewed included deregulation, self-regulation and negative licensing. While these approaches have been assessed as capable of delivering differing levels of benefit it is considered that they alone are not enough to provide the degree of protection sought through the existing statutory registration program. It is considered further that there

continues to be market failure, allied with major health and safety risks that are, at this time only addressed by a scheme of statutory registration of health professionals. The legislative controls are intended to minimise the risks of adverse health impacts while enhancing the benefit to be gained. Notwithstanding this assessment however many of the existing legislative restrictions are considered in need of modification in order to focus them on their consumer /community protection purpose. In some instances, particularly in relation to restrictions on business a case is considered to exist for the removal of a substantial degree of regulation. Such changes to the legislation are also anticipated as assisting the economy to function more efficiently.

While this review is focussed on addressing the existing legislative restrictions a related and concurrent process is targeting reform in terms of the general operation and focus of the legislation. The following recommendations therefore relate to the anti-competitive elements of the existing health professional legislation.

9.1 Registration of Health Professionals

The objective of health professional registration legislation is to protect health consumers as an outcome of mandatory standards that are enforced in relation to a health professional's entry to practice and continuing fitness to practice. Support for such statutory requirements is based on an understanding that the community's interests would not be promoted by an unrestricted health professional market.

The Review has identified the registration (market) restrictions that arise within health professional legislation and has discussed the benefits and costs of such provisions. Further, the review has looked at alternatives to legislative registration requirements. In relation to the specific restrictions the following discussions outlines the reform initiatives that have been recommended.

9.1.1 Entry restrictions

The primary objective of legislative restrictions on entry to professions is to address issues of information asymmetry in the health professional service market. These restrictions are aimed at overcoming difficulties associated with consumers making an informed choice about their health service provider when they are relatively poorly informed about the nature and quality of service available as compared to the information held by the provider.

Distributional analysis of the costs and benefits of entry restrictions indicate that there are significant, although usually indirect, costs in maintaining entry restrictions. Forgone competition, a restricted provider base, premium service price, and the underwriting of educational costs are all significant costs that are largely met by the community. The community however also accrues benefit from entry restrictions in the form of broad confidence in the competence, conduct and service standards of health providers. Significant benefit is also delivered by entry standards in the form of enhanced health, productivity and reduced costs from health treatment misadventure.

The retention of entry requirements also provides an efficient means for other public programs to identify and nominate appropriately qualified and competent health professionals.

On balance it is considered that the public interest is promoted by statutory entry requirements. There remain sufficient public risks from the consequences of asymmetry of information and negative spillovers to support the continued expression of entry restrictions in legislation. Additionally, while the alternatives to regulation may provide varying levels of consumer protection they are, on their own an insufficient response to consumer risks.

Along with the retention of entry restrictions in legislation it is considered that the legislation should also restrict the use of professional title. Such a restriction provides direct confirmation to consumers that a person using a professional title has fulfilled minimum requirements for membership of the profession. It is not considered however to necessarily follow that the legislation should, as attempted currently, restrict an entire scope of practice to a particular professional group. The risk costs of stifling contestability and innovation, restricting consumer choice, and duplicating other consumer legislation is judged to outweigh the benefits of this broad restriction.

Respondents to the consultation reports have overwhelmingly supported the retention of statutory restrictions on entry. Respondents considered that the value of entry restrictions as a means to achieve the objectives of the legislation outweighed any costs. Appendix 2 outlines a synopsis of respondents comments in relation to entry restrictions.

The principles supporting the retention of entry standards focus on the need to protect health consumers from direct harm from an unqualified or otherwise unfit health professional. The principle is not however considered to extend to the dental technician's profession. Dental technicians do not work to the public but rather work to the 'order' of a registered dentist or dental prosthetist. Accordingly it is considered the responsibility of the dentist or dental prosthetist to ensure the standard of a dental technician's qualifications and competence. While there are some public risks associated with the work of a dental technician these risks are considered to be low and appropriately managed through the application of infection control and occupational health and safety legislation.

Recommendation 1

1.1 Entry Qualifications

(a) That entry to a registered profession be determined by a health professional's fulfilment of statutory fitness requirements.

(b) That the fitness requirement be expressed as-

- **Nationally recognised profession specific qualification requirements;**
- **Physical and mental fitness as defined within the legislation;**
- **Successful completion of any nationally sanctioned training or internship program;**

- **A sound knowledge of the English language and possession of sufficient skills in the expression of English, both written and oral, as are nationally required for the practice of the health profession;**
- **Payment of a registration fee; or**
- **Application made on the basis of the operation of the *Mutual Recognition Act 1992* or *the Trans Tasman Mutual Recognition Agreement (where it applies).***

1.2 Title restriction

(a) That the legislation confer exclusive use of title on persons who have been accepted as meeting the statutory entry requirements.

1.3 Scope of Practice

(a) That the legislative benefit of protection of title not be further extended to include legislative restrictions on practice by unregistered persons.

1.4 Dental Technicians

(a) That the dental technicians profession not be considered a registrable profession in the ACT.

9.2 Conduct standards

Restrictions on professional and business conduct through regulated conduct standards are aimed at providing quality control and promoting quality assurance signals to the health consumer. As with entry standards the restrictions are intended primarily at addressing information asymmetry in the health market. Consumers are offered protection through the standards from inappropriate provider selection or exploitation by providers. The legislation intends that providers, in return for benefiting from the legislative restrictions on entry, are required to demonstrate their continuing (protective) practice standards.

The distributional analysis of the costs and benefits of statutory conduct standards categorised the standards as being related to either professional or business conduct.

In relation to **professional standards** the costs of the restrictions were identified as being primarily incurred by the profession and the community in general. The professions experienced cost in terms of potential restrictions on practice and the resulting incentive to maintain conservative professional conduct. The community experienced costs primarily in terms of maintaining a health complaint infrastructure, and potential restrictions on provider choice. Benefit of the restrictions primarily accrued to the health consumer wherein they were protected from the consequences of treatment by persons who were not competent or fit to provide health care. Benefit was particularly linked to the redress of information asymmetry and potential avoidance of negative spillover effects. Unfettered conduct is likely to be both inefficient and inequitable.

The overall distributional benefit associated with professional conduct standards favours a their retention. Such restrictions provide for safe access to health services by consumers who might otherwise be severely disadvantaged in their health care transaction. While there is considered to be benefit in having professional conduct restrictions there is acknowledgment that the existing restrictions have potential to be applied beyond their protective intent and for professionals to over-comply. Accordingly it is proposed that the conduct standards themselves be revised by removing general standards and replacing them with specific conduct prohibitions. (These changes are discussed in the context of broader regulatory reforms to the operation of the Act)

In terms of business conduct restrictions the review has identified as anti-competitive restrictions on advertising and a number of restrictions relating to only one profession.

Advertising – Analysis of the distributional costs of advertising restrictions shows that providers, the consumer and the community share costs. Such costs arise from restrictions on how a health professional can market and expand their services, restrictions on how consumers can develop and make informed choices as to their health service purchase, higher prices for services and the costs of supporting inefficient or less competent providers. Costs are also incurred in the duplication of certain advertising restrictions in other regulatory measures eg Fair Trading legislation. The benefits of the restrictions chiefly concern protection of health consumers from the health and financial consequences of false and misleading

advertising. In addition consumers may be protected from higher health costs that reflect the costs of advertising. Some health professionals may also benefit from protection from scrutiny by an informed health-purchasing public.

The level of intervention necessary for managing the assessed risk appears to be less than currently applies. The costs and benefits of retaining substantial advertising restrictions requires a judgement to be made. On balance there is considered to be strong argument for the removal of many of the current barriers to advertising by health professionals. The economic benefits arising from a more informed public and less regulatory duplication are considered to outweigh the costs of maintaining broad advertising controls.

While the proposition to relax advertising regulations has considerable merit there is a counter proposition that also has benefit. There are concerns that 'misleading advertising' including advertising that over-promotes benefit may pose immediate health protection concerns particularly for vulnerable consumers. Moreover there is concern that other regulatory measures (such as *Fair Trading* legislation) may not be able to respond with the speed, equity and effectiveness of action taken to protect the public under a health professional Act. Accordingly there is a justifiable case against total deregulation and a benefit in including 'misleading advertising' as a breach of a professional conduct standard. While such a standard would not prohibit advertising it would permit a regulatory authority to take action where public safety is compromised.

Consultation on advertising restrictions has generally supported the above findings. In many instances the above proposals reflect the status quo with most regulatory authorities having substantially relaxed their enforcement of the more rigid of the controls on advertising. A synopsis of consultation comment on this issue is at Appendix 2

Possession of Professional Indemnity Insurance – Dental Prosthetists. – A registered dental prosthetist may not provide a dental prosthetic service unless they have professional indemnity insurance related to that service. The direct costs of this restriction are essentially costs to health professionals from maintaining such coverage. Health consumers can also expect to pay a marginally higher fee as the costs of insurance are recouped as part of service costs. The benefits of the restriction are largely potential protection from loss by consumers and the community in the case of negligent care. The requirements to hold professional indemnity insurance does not, in itself provide direct protection from an unfit health provider. Rather it may only make it more certain that a successful negligence claim is fully compensated. While such provisions reinforce good commercial practice it is not clear that the impost provides either a demonstrable public benefit or belongs in legislation concerning the direct fitness and standards of a health professional.

Although there is support for this legislative provision and a clear recommendation, through the consultative process, for the requirement to be extended to all health professionals the retention or extension of the provision is not supported. Prior to any such requirement being introduced in the future it should be subject to a profession based cost benefit analysis along with a review of the many practical issues

surrounding such a proposal. The introduction of any such proposal would also be more relevant to a trading or business licensing regulatory framework.

Restrictions on practice – Dental Hygienists and Dental Therapists. – The Dental Act restricts the occupational activities of dental hygienists and dental therapists to specified procedures. In addition the Act restricts dental therapists to working in the public sector and requires that they only provide care to children. The costs of these restrictions are generally distributed across the industry. These health professionals have restricted capacity to engage in business, there is reduced provider choice and reduced innovation in service delivery. The benefits of the restrictions arise from limiting the application of such health professional skills to the area of their training and as such minimising the effects of misadventure. The particular provisions are however anomalous to any other health profession. In addition, and as is the case with other professions, there are surrogate provisions relating to safe standards of professional practice. These standards are considered to be applicable to a hygienist, a therapist and any registered dentist who may direct their activities. On balance it is felt that there is greater potential economic and community benefit from removal of the provisions than from their retention.

Consultation in respect of this provision elicited both strong support and strong opposition to the proposal (Appendix 2). It is considered that many of the concerns could be addressed through an active regulatory authority that had a balance of representations across the dental professions. Accordingly separate recommendations have been made on the establishment of a dental council and the representation of all registered dental occupations.

Restrictions on prescribing spectacles and contact lenses – The *Optometrist Act 1956* has specific provisions restricting the sale of spectacles or contact lenses that have not been prescribed by a medical practitioner or optometrist. The significant costs of this restriction are again in terms of restrictions on persons who may enter the market and restrictions on provider and price choice. While the optometry profession in theory benefits from restricted market entry there is also benefit to the consumers from treatment by persons highly qualified in eye physiology, eye disease, and diagnostic assessment. Without the benefits of an optometrist's training it is likely that consumers will be at risk from inappropriate prescribing and the long term consequences of misdiagnosed eye disease. While there is a case in principle for removing market place restrictions it is acknowledged that there is quite active competition between individual optometrists. The market benefit of any deregulation would be greater if optometrists were not as accessible and competitive. On balance there appears to be no overwhelming benefit of removing the restrictions on market supply. Rather there appears to be a public protection and benefit case for the restriction to remain.

Consultation on this issue largely supported the retention of the restrictions although there were concerns expressed by a group of potential alternate providers. There is a case for a more focussed assessment of the restriction in the future.

Conclusion

While it is intended to retain the principle of statutory restrictions on certain professional and business conduct standards there is an acceptance that these standards, as currently presented, should be substantially revised. Certain of the existing restrictions are either presented in language that would allow application beyond the protective intent of the legislation or otherwise provide minimal public benefit. As a general rule it is intended that the legislation be focussed on protecting the public where there is a direct and foreseeable risk. Where there is no direct risk or that risk can be managed through other processes than legislative provisions relating to health professional registration should not be reinstated.

***Recommendation 2*.**

Continuing Standards of Conduct

2.1 That the legislation maintain requirements for the continuing standard of conduct of health professionals including that –

a) core standards apply universally to all registered health professions;

b) current generalised standards be recast as specific, unambiguous conduct requirements that have an identifiable and direct public benefit/public protection role;

c) existing conduct requirements that relate generally to business activity such as restrictions on advertising, (including the Medical Practitioners (Advertising) Regulation), requirements for dental prosthetists to possess professional indemnity insurance, and restrictions on dental hygienists and dental therapists not be reinstated;

d) the legislation include a professional conduct standard relating to misleading advertising;

e) the restrictions on non-optometrist prescribing of spectacles and contact lenses remain, but that they be subject to further review, and

f) where, in the future, new provisions relating to business activity within specific professions are sought these should be introduced only after rigorous regulatory analysis.

9.3 Regulatory Authorities

The health professional legislation confers responsibility for administering the legislation on individual health professional Boards. The membership of these Boards are almost entirely drawn from that particular health profession. Health professionals bring to Boards the benefits of their clinical knowledge, guidance and peer review capacity. Such "intelligence" as to the safe conduct of health practice is likely to be otherwise unavailable or otherwise only accessible at a high cost to the community. Boards under current operations are essentially self funding and provide a relatively efficient and effective means to implement legislative requirements.

Where there is to be legislation governing the registration and conduct of health professionals there is a need for a structure to administer the legislation. This review has considered the cost and benefits of the existing professional board structure and comparative costs and benefits of alternative structures. On balance and with provisions for greater consumer/government accountability, a reduced disciplinary role and more active performance monitoring, a board type structure is considered to offer the greater public benefit than the alternatives.

No stakeholders proposed the abandonment of regulatory Boards and all were supportive of their overall efficiency and effectiveness in administering the legislation. Notwithstanding this support however there was also endorsement of the need to overhaul the operation of Boards and improve in particular their community representation, enhance their protective services, overhaul appeal provisions and reduce their involvement in complaint investigation and disciplinary action. Reforms in these areas have been put forward in the context of the broader review of the operations of the Acts.

Recommendation 3

That the legislation-

(a) continue to be administered through regulatory bodies composed of majority members of the relevant health professions;

(b) be revised to -

- **Remove the registering bodies from direct involvement in the management of report investigations.**
- **Limit these regulatory bodies in the exercise of disciplinary action that may involve the suspension or de-registration of a health professional.**

(c) include appropriate references to avenues of review of regulatory body decisions.

Appendix 1

Description of Entry Requirements

Fitness to practice

While no Act directly defines fitness to practice this requirement can be read as linked to requirements that exist in all but the *Dental Technicians and Dental Prosthetists Act 1988* that applicants for registration have

> *sufficient mental capacity, physical capacity and skill to practice in the profession.*

and are not impaired;

> a person is impaired if *a person suffers from any physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect the persons physical or mental capacity* to practice in a particular health profession.

These Acts expand on this definition as including

> *habitual drunkenness or addiction to a deleterious drug to be a physical or mental disorder.*

All Acts have a further requirement that applicants have at least a knowledge of the English language with most requiring that an applicant;

> *has sufficient communication skills* for practicing in a registered health profession *including an adequate command of the English language.*

Further qualification of fitness to practice can be read as including reference to the offence history of the applicant. With the exception of *Dental Technicians and Dental Prosthetists Act 1988* all Acts have provisions that an applicant may be refused registration if;

> *convicted of an offence... by a court....if the Board is of the opinion that the conviction renders the person unfit in the public interest to practice.*

Where Acts have provision to facilitate registration under the Mutual Recognition Act or from other ‘foreign‘ applicants, the Acts have provisions to enable the refusal of registration where the applicant has been de-registered under foreign law.

> An applicant for registration may be refused where *an applicant’s name has been removed from a foreign register of health professionals for any reason relating to their conduct as a health professional or relating to the person’s physical or mental capacity to practice in that profession.*

Qualification requirements

Qualification requirements are established in each Act for each registered health profession. Typically requirements are common and include a person being a graduate;

> *in a course of education offered by an Australian institution being a course accredited by the Board or approved by a registration authority of a State or another Territory* or has *passed such examination as the Board requires.*

In most Acts Boards have further discretion to require that a person has,

> *undertaken such further education or training or gained such experience in practising in the health profession for such a period as the Board determines.*

Specific qualification requirements are established within the Acts for specialist positions.

- Midwife and Mental health nurse - Nurses Act.
- Specialist Veterinary Surgeon - Veterinary Surgeons Act.
- Specialist Dentist - Dentist Act.

In the case of requirements for medical practice and psychology there are additional provisions requiring the applicant to have completed a period of

> *supervised training or internship*.

Prescribed fee requirements

All Acts require the payment of a fee as a pre- requisite to obtaining and renewing registration within each health profession.

> *a registered health professional shall on or before a specified date each year pay to the Territory the determined fee.*

Where the Acts have mutual recognition principles,

> *a person who applies for registration under the Acts pursuant to the Mutual Recognition Act shall pay the determined fee.*

Mutual recognition

All Acts have provisions for the mutual recognition of the training/ qualifications of a health professional achieved under the law of another State or Territory. eg;

> *a person who is registered as a health professional under the law in force in a State or another Territory, that is a participating jurisdiction within the meaning of the Mutual Recognition Act is entitled to be registered as a health professional under this Act.*

Fitness to practice

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> *sufficient mental capacity, physical capacity and skill to practice in the profession.*

and are not impaired;

> a person is impaired if *a person suffers from any physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect the persons physical or mental capacity* to practice in a particular health profession.

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Further qualification of fitness to practice can be read as including reference to the offence history of the applicant. With the exception of *Dental Technicians and Dental Prosthetists Act 1988* all Acts have provisions that an applicant may be refused registration if;

> *convicted of an offence... by a court....if the Board is of the opinion that the conviction renders the person unfit in the public interest to practice.*

Where Acts have provision to facilitate registration under the Mutual Recognition Act or from other ‘foreign‘ applicants, the Acts have provisions to enable the refusal of registration where the applicant has been de-registered under foreign law.

> An applicant for registration may be refused where *an applicant’s name has been removed from a foreign register of health professionals for any reason relating to their conduct as a health professional or relating to the person’s physical or mental capacity to practice in that profession.*

Non-registered not to practice

All Acts have general provisions prohibiting non-registered health professionals from practicing in the professions.

> *A person who is not registered in the health profession shall not provide/give /perform/practice/carry on a health service for fee or reward.*

This prohibition is further confirmed by provisions in all Acts that restrict use of title or name of a health professional.

> *A person other than a registered (health professional) shall not take or use any other words or letters, the name title of a (health professional) or a name, title, addition or description,(including initials or letters placed after a persons name) indicating or implying that the person is registered as a (health professional) or that the person performs, or is qualified to perform/practice, (health professional) work.*

Most Acts further prohibit a person other than a registered health professional from advertising to provide a health professional service.

A non registered health professional may not hold him or herself out by advertisement or otherwise, as being qualified or authorised to practice in the health profession or as being a person who practices in the health profession.

Appendix 2

Consultation Comments

Statutory restrictions on entry

Respondents to consultation reports have indicated overwhelming support for the retention of statutory entry restrictions within the existing health professional legislation. There were no dissenting views, examples of comments were as follows –

- *The association supports, in principle, the mechanism of registration which includes statutory entry standards...means of ensuring only suitably qualified people perform certain health procedures*
- *Our association is in favour of legislation that ensures a high standard of competency and training ...it is the responsibility of government to ensure community safety..through the legislative arm..*
- *Statutory regulations provide the public with a consistent base line standard of professional competence in health care delivery. the removal of such regulation would create substantive risks to public health*
- *The health care market is an imperfect market ...demand is not constrained by price and the consumer faces a marginal cost at the point of receiving care that is less than the real marginal cost of provision...introducing competition ...will improve productivity but it does not address the basic defects of the market mechanism as a method of delivering health care. impediments like consumer ignorance, the problems of uncertainty and externalities necessitate regulation and registration.*
- *Persons holding themselves out as registered health care providers must be competent in the delivery of those services to minimise risk to the public. ..attaining a qualification which is necessary to ensuring competency is an objective criterion for attaining registration...there should be a consistent approach to the expression of entry qualifications. eg the possession of nationally recognised qualifications.*

Statutory restrictions on conduct

Respondents were asked to express views on the existing conduct restrictions and potential changes to them. Overall responses were clearly in favour of the retention of conduct requirements in legislation. There was a array of views however as to how the conduct standards should be expressed. Support ranged from calls for the maintenance of existing standards as a whole or in part, to support for a schedule of revised standards of practice and the introduction of additional standards.

In relation to the maintenance of existing standards comments such as the following were received –

- *The existing conduct standards are valid…with exceptions such as.."bringing the profession into disrepute" this is inappropriate in an Act ...realy a matter for professional association...rather than legislation.*
- *Existing conduct provisions should be maintained ...doctors have understood and maintained these ethical imperatives for over 2000 years.*

- *favour keeping the current conduct standards…the public is not in the position to judge quality in this profession.*

Views expressed in relation to a revised standards of practice schedule included –

- *support amendments… remove anti-competitive restrictions…promote fair trading in an open market place.*
- *generally agree with proposals.*
- *the board agrees in principl…benefit in maintaining intent of provisions the table (provided in discussion Paper)..is indicative of acceptable standards of practice.*

In addition to responses in relation to the above issues many respondents also volunteered information about the proposed deletion of advertising standards. They also provided information on additional standards that could apply to the professions. Representative comments were as follows –

- *Some reservations are held about the removal of restrictions on advertising from health professional registration…the capacity for the general public to adequately assess advertised services and particularly choose appropriately in the presence of cost differences is a concern.*
- *advertising should be permitted provided it falls within guidelines…truthful not claiming professional superiority… or offering inducements.*
- *the board is of the opinion that Professional Indemnity Insurance (PII) is in the public interest…like to see expanded debate with a thought to include requirement for all Boards,*
- *extending the PII requirement to all health practitioners should be pursued community expects registered health professionals to be insured.*
- *PII should be compulsory.*
- *Recency of practice…if a practitioner has not undertaken clinical practice for an extended period of time, an argument could be put that the public may be put at risk unless the applicant completes a period of retraining or supervised practice*

Restrictions on practice – including restrictions on dental hygienists and dental therapists

Under the existing legislation dental auxiliary professions are restricted by the legislation to performing certain practices. In addition other individual health professional Acts sought to restrict a broad scope of practices to individual professions. The Department in its discussion papers proposed that such forms of practice restriction had questionable benefit. The Department also proposed that unless net benefit could be demonstrated the restrictions be either substantially modified or removed. Responses to these proposals are indicated by the following selection of comments –

- *the board does not support the removal of broad scope of practice provisions...such guidelines are necessary*
- *statement should include a requirement that practice be restricted to areas of educational preparation or credentialing.*
- *agree that legislation should not restrict whole scope of practice but should enable restrictions of specific practices.*

- *There should be restrictions on practices that are unique to a particular profession and (are) demonstrably harmful if practiced by persons outside the profession*
- *The board supports the removal of whole of practice restrictions…such restrictions would limit the development of the professions, would fast become outdated and serve no purpose in the protection of the public.*
- *The associations national position is that the public is not adequately protected by largely relying on restrictions of the use of professional titles to registered practitioners…have argued that registration Acts should contain a definition of physiotherapy so that everyone is aware of what the Acts are regulating.*
- *The association supports the removal of broad scope of practice restrictions from the legislation…the legislation as it stands clearly allows for anti-competitive applications of the Acts to protect "professional turf"…support that only those practices that are demonstrably harmful should be restricted.*