REPORT

CENTRE FOR
INTERNATIONAL
ECONOMICS

NCP review of the Northern Territory Medical Act

Prepared for Territory Health Services

FINAL REPORT

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Executive summary

THE REVIEW OF THE *MEDICAL ACT* is one of 12 reviews being undertaken of the Northern Territory's health legislation under National Competition Policy (NCP) requirements.

This NCP review has followed the recommended steps for undertaking such reviews. After preliminary discussions an issues paper was developed which set out the:

- explicit and implicit objectives of the legislation;
- nature of every restriction on competition; and
- likely effects of the restrictions on competition and on the economy generally.

This report includes recommendations formed after receipt of submissions and public consultations following the release of the issues paper. These consultations and submissions formed the basis of the:

- assessment of the balance between the costs and benefits of the restrictions; and
- consideration of alternative means of achieving the same results including nonlegislative approaches.

The guiding principles for professional registration that were assessed to be in the public interest as a result of this and the other reviews undertaken are as follow.

- Title protection — right to exclusive use of title — is in the public interest as it provides information not only about the initial qualifications, but also about competency in that the registered professional is subject to the discipline of the professional board which has the right to impose penalties and to deregister the professional for professional misconduct.
- The board should have the powers to examine and declare practices of high public risk and cost as restricted practise areas, but be required to follow a procedure that ensures that such declarations are only made when there is a clear case of public interest.

- Appropriate fees should be charged for registration and the issue of certificates and licences to assist in covering the cost of the administration of the acts. Fees were not of sufficient magnitude to restrict entry.
- Qualifications required for eligibility for registration be determined by the board and not listed in the act. The fairness of the board's decisions is enforced by the right to appeal, and supported by the mix of professions and public representatives on the board.
- What constitutes good fame and character, fitness to practise and similar provisions should be clarified in the act, but judgement on satisfaction of these criteria should be left to the board.
- Similarly, judgement of what constitutes professional misconduct, or unprofessional conduct should not be enscribed in the act. There is adequate case law to define these requirements.
- Restrictions on advertising are unnecessary restrictions on competition and may limit information available to consumers. Advertising in a false or misleading manner may be considered professional misconduct, and the board would have the power to address this as outlined above.
- Restrictions on the structure, ownership and practise of professional companies do not provide effective protection for the public. As other legislation provides this protection, such provisions are redundant and should be repealed.

Following these principles it is recommended that the following sections of the act be rescinded.

- Section 56(1)(a) — only persons who are registered medical practitioners in the Northern Territory, and who hold a current Northern Territory licence, are permitted to provide medical services in the Northern Territory for a fee.
- Section 58 — only registered medical practitioners can hold medical appointments.
- Section 62(2) — anyone who is not a registered medical practitioner cannot use the court system to recover fees charged for medical services performed.
- Section 27(2)(e) — the requirement of residency in the Territory for eligibility.
- Section 38(2) — which contains restrictions on advertising as a component of unprofessional conduct.
- Section 54:
  - precludes persons other than medical practitioners with other medical practitioners, or an individual medical practitioner with only one other person who is not a medical practitioner, from forming a medical company; and

- requires that the Medical Board must approve the name and constitution of a medical company.

These sections of the act potentially limit competition. They could not be demonstrated to be of sufficient public benefit to outweigh the potential costs. In addition, recommendations to strengthen the public benefit by enhancing the information value of the professional title are made. These include making the objectives explicit in the act, requiring all board members to represent the public interest, clarification of what is meant by good fame and character, giving the board greater flexibility in deciding on appropriate qualifications for eligibility and the power to require demonstrated competence for renewal of license to practise.

Alternatives to professional registration for protecting public health were considered. The benefits to the public through improved information and the support for professional conduct and competency provided by the activities of the Board under the act could not be achieved at lower cost by any alternatives such as public information or negative registration.

1 Introduction

THE CENTRE FOR INTERNATIONAL ECONOMICS (CIE), a private economic research consultancy, in conjunction with Desliens Business Consultants has been commissioned by Territory Health Services (THS) to undertake an independent review of the *Medical Act* in accordance with the principles for legislation review set out in the Competition Principles Agreement (CPA) entered into by all members (Commonwealth, states and territories) of the Council of Australian Governments in 1995. The review forms part of the Northern Territory government's obligation under the CPA to review and, where appropriate, reform all laws that restrict competition by the year 2000. Legislative reviews along National Competition Policy (NCP) lines are currently being undertaken of health and health related acts in other states. The Commonwealth is also conducting NCP reviews of its health legislation.

The *Medical Act* is one of 12 Northern Territory health acts to be reviewed (box 1.1).

In undertaking this review we held preliminary consultations with stakeholders involved in the provision of dental services in the Northern Territory, including officers of THS. A number of relevant documents were reviewed, including a 1998 review of the professional boards. An issues paper was prepared and made available on the THS website. The issues paper worked through the various steps of an NCP review and raised questions and issues to be addressed at each step of the review. The issues paper identified those parts of the act that potentially restrict competition.

Newspaper advertisements drew attention to the review and the issues paper and called for submissions from interested parties. Two submissions were received from Geoff Clark (Director, Professional Boards) and Dr Chris Harrison (Top End Division of General Practice). Further consultations were held with interested parties to discuss aspects of their submissions. This report documents the findings and recommendations of the inquiry.

1.1 Acts to be reviewed

- ***Medical Act***
- *Dental Act*
- *Optometrists Act*
- *Radiographers Act*
- *Community Welfare Act*
  - Community Welfare Regulations
  - Community Welfare (Childcare) Regulations
- *Health Practitioners and Allied Professionals Registration Act*
- *Nursing Act*
- *Mental Health and Related Services Act*
- *Public Health Act*
  - Public Health (Barber's Shops) Regulations
  - Public Health (Shops, Eating Houses, Boarding Houses, Hotels and Hostels) Regulations
- *Private Hospitals and Nursing Homes Act*
- *Medical Services Act*
- *Hospital Management Boards Act*

2 *The environment in which the Medical Act operates*

THE IMPACT OF GOVERNMENT legislation on competition depends very much on the actual and potential structure of the market. How big the market is, what type of services are wanted and who pays for the services are important, as are the features of supply.

In 1997, at the time of the labour force survey, there were 395 persons working as medical practitioners in the Northern Territory. Of these 198 were primary care practitioners (general practitioners or other medical practitioners), 106 were specialists and 91 were non-specialists working in public hospitals (interns and other hospital staff). At 114 per 100 000 people, the number of primary care practitioners was slightly higher than the Australian average of 110.4 per 100 000 people. However, the number of specialists was low at 56.3 specialists per 100 000 compared to an Australian average of 85.9 specialists per 100 000. There are around 600 registered medical practitioners who reside permanently in the Northern Territory and around 1000 who are registered in the Northern Territory.

The demand for medical services

The size of the market and the types of services required depend on population size, its demographic structure and population health status. Who pays for medical services is the consequence of a complex cost sharing arrangement between the federal and territory governments, and individuals. This arrangement also influences demand.

Demographics

The population of the Northern Territory was estimated in 1995 at 173 878. The population is growing faster than the rest of Australia, with an average growth rate of 6.2 per cent between 1990 and 1995. The majority of the population (76 per cent) live in the urban areas of Darwin (and surrounds), Nhulunbuy, Katherine, Tennant Creek and Alice Springs. Aboriginal people make up 27 per cent of the Northern Territory population, with two thirds living outside the urban areas.

The demographic profile shows a young population with 44 per cent of the population under the age of 25 and only 3 per cent over 65. Sixty-one per cent of the Aboriginal population is under the age of 25.

Younger populations generally require fewer medical services than older populations. Some specialist services such as obstetrics, and accident and emergency will face relatively higher demand in the younger population. Other services such as orthopedics, ophthalmology and cardiothoracic will face relatively lower demands than in the older population.

Health outcomes

For the majority of the non-Aboriginal population the standard of health is good. This is a function largely of the young average age of the population. However, injury rates are relatively high, as is the incidence of sun related skin cancer.

The health outcomes for the Aboriginal population are poor and the gap between Aboriginal health outcomes and non-Aboriginal health outcomes has not been reduced and may have widened in recent years. Poor nutrition and climate related infectious and parasitic diseases have contributed to high levels of morbidity and mortality. Particular causes of these higher that average levels have been identified as:

- circulatory
- respiratory
- injury
- diabetes
- renal failure
- pelvic inflammatory disease
- infectious and parasitic disease.

Main areas of demand for medical services

The high proportion of Aboriginal people and the relatively young population create demands for medical services that differ somewhat from the Australian average. And the Northern Territory has specific problems related to climate — skin cancer and tropical infectious and parasitic diseases — as well as problems arising from the high consumption of tobacco and alcohol, and poor nutrition.

Primary care services — preventative and early intervention — are particularly important for the health of the Northern Territory population.

Funding of medical services

In many situations the government — federal government in the case of Medicare payments, and state or territory governments for many public hospitals based services — is the purchaser of medical services. When medical services are privately provided — in or out of hospital — Medicare generally picks up the majority of the payment for service. Medicare payments for services are prescribed under the Medical Benefits Schedule. Services provided by medical practitioners in hospitals to private patients are rebateable at 75 per cent of the scheduled fee. Private insurance can be purchased that covers the other 25 per cent of the scheduled fee. The consumer must meet charges in excess of the scheduled fee.

Across Australia the majority of services provided by general practitioners are purchased directly by consumers as private patients. These consumers are insured through Medicare, although depending on the cost of the service, the Medicare rebate may not cover the service charge. As with medical services provided in hospitals, insurance cover for the gap between the fee charged by the general practitioner and the scheduled fee is not available. In the Northern Territory, due to a shortage of private practitioners in the rural and remote areas, these primary health care services are more likely to be provided by salaried general practitioners employed by THS than by private general practitioners. The implication is that a higher share of services provided by general practitioners is funded by the Northern Territory government than in other states and territories.

Specialist services are provided both publicly and privately. In the Northern Territory, the majority of specialist services are publicly provided by salaried specialists in the public hospitals. Specialists also provide private services in private and public facilities on a fee for service basis. These fees are rebateable under Medicare and private insurance as described above. However, unless the specialist is a member of one of the colleges of medicine in Australia these services are only eligible for the general practitioner rebate ($17), rather than the specialist rebate ($50).

Hospitals

Hospitals are the main purchaser of specialist medical practitioner services. There are five public hospitals and one private hospital in the Northern Territory. The public hospitals are:

- Royal Darwin (297 beds and 97 per cent occupancy rate)
- Alice Springs (170 beds and 90 per cent occupancy rate)
- Katherine (60 beds and 65 per cent occupancy rate)
- Tennant Creek (20 beds and 62 per cent occupancy rate)

- Gove (30 beds and 69 per cent occupancy rate).

The private hospital is located next to Royal Darwin and has 130–140 beds and an occupancy rate of 30 per cent.

In 1996-97 the number of separations (individual patient stays during which the patient may have received multiple procedures) in the public hospitals was 48 316. Of these, 56 per cent were Aboriginal patients and 21 596 were day surgery. The average length of stay, excluding same day patients, was 6.3 days. Table 2.1 shows the number of separations at each public hospital. This provides an indication of the level of demand for specialist medical services.

2.1 Number of separations

Hospital	*Authorised beds 1998-99*	*Total separations 1996-97*	*Bed utilisation 1996-97*
	No.	No.	%
Royal Darwin	295	25 362	93
Alice Springs	160	15 901	89
Katherine	60	3 496	65
Tenant Creek	20	1 481	62
Gove	30	2 076	69

Source: Territory Health Services annual reports (1996-97 and 1998-99).

Supply of medical services

Medical practitioners

In December 1999 there were 1022 medical practitioners registered with the Medical Board in the Northern Territory. Of these, 601 listed Northern Territory addresses as their residential address. However, in the 1997 labour force estimates made by the Australian Institute of Health and Welfare only 395 medical practitioners were reported as working in the Northern Territory at that time.

It is estimated that around 41 per cent of primary care practitioners are employed by THS or community based health services and 59 per cent are in private practice. General practitioners are employed by THS and community based health centres to work in rural and remote areas, usually covering a wide area on a rotational basis. Twenty-two per cent of the general practitioners in the Northern Territory have the majority of their work in Aboriginal health.

The provision of general practitioner services in the Darwin urban area has improved recently, with four after hours services now being available. However, rural and remote provision of services is more complex (Top End Division of General Practice submission). As pointed out in the submission, the difficulties in

ensuring provision of medical services in these areas is not an issue of competition, but of the need to provide the environment to attract medical practitioners to work in these areas. A number of approaches have been trialled and provision of incentives such as the RIP/Remote Area Grants Program, NTRHWA and Rural Retention Grants have increased the number of general practitioners able to stay in remote areas.

The Northern Territory has a much higher proportion of salaried hospital non-specialists than other states. In 1997, 37 per cent of hospital medical staff were non-specialists compared to an Australian average of 25 per cent. Of these, only 63 per cent were interns compared to the Australian average of 75 per cent, implying a much higher proportion of non-specialist salaried medical practitioners in Northern Territory hospitals than in most areas in Australia. All of these salaried staff were employed in public hospitals.

The distribution of specialists in the Northern Territory differs from other states and territories in Australia. Northern Territory is alone in not having a specialist in cardiology. This is a result of the small population and relatively young age of the population. They also have a higher share of paediatric medicine specialists (11.3 per cent of specialists in the Northern Territory compared to 4.7 per cent nationally), again reflecting the demographics of the population. Specialist services to remote areas have been the responsibility of the government as costs of provision are very high and there is insufficient population to support private provision of such services. The recent Specialist Outreach Services funded by the Commonwealth have improved the availability of a number of services in remote areas (Top End submission).

Other suppliers of services potentially effected by the act

While the act states that only registered medical practitioners can supply medical services, there are a number of alternative service providers that effectively compete, in that they provide services that are substitutes for some services provided by medical practitioners.

- Midwives can provide midwifery services that may substitute for obstetric services.
- Nurses can provide primary care services that may substitute for services provided by general practitioners. Areas exclusive to medical practitioners are the power to prescribe schedule 8 drugs and to refer to specialists.
- Aboriginal health workers can provide services similar to those of registered nurses.

Government administration of the act

The Professional Registration Boards section of THS administers the act. The main administrative activities associated with the act are:

- processing of applications for registration;
- maintenance of registers;
- renewal of registration;
- convening of board meetings;
- organisation of board activities — for example, hearings on 'impaired practitioners'; and
- administration of disciplinary decisions — for example, removal from the register.

National issues

The *Health Insurance Act 1973* set up the Medicare Scheme. This scheme limits public insurance (Medicare rebate) to those services provided by a medical practitioner who has a Medicare provider number. In recent years limiting the number of Medicare provider numbers has been used as a tool to control public health care costs. There is no requirement in the Northern Territory act for a registered practitioner to have a Medicare provider number. However, it would be almost impossible to conduct a fee for service business without a Medicare provider number.

3 NCP principles

UNDER THE CPA, nearly 2000 pieces of Commonwealth, state and territory legislation are being reviewed over a six year period. The guiding principle behind these reviews and the reforms that follow them is that legislation (encompassing activities of authorities set up under that legislation and any regulations, rules, etc. authorised under it) should not restrict competition unless it can be demonstrated that the:

- benefits of the restriction to the community as a whole outweigh the costs; and
- objectives of the legislation can only be achieved by restricting competition.

It is significant to note that *both* of these criteria are required to be met if a restriction is to be retained. This means that even if a restriction passes a net public benefit test, it should not be retained if there are other less restrictive ways of achieving that outcome. Also, if a restriction is to be retained, it is necessary to demonstrate that to keep it will result in a public net benefit. It is not sufficient to demonstrate that its removal would result in no or little net benefit.

It is important when assessing the benefits and costs of a restriction that distinctions are made between private benefits and costs, industry benefits and costs and communitywide benefits and costs.

The CPA does not define how any piece of legislation should be reviewed. However, it does state that, without limiting the issues that can be addressed, it should:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess and balance the benefits and costs of the restrictions; and
- consider alternative means of achieving the same results including nonlegislative approaches.

The CPA lists a range of public interest issues that are to be taken into account where relevant in assessing the benefits and costs of any restrictions. These include:

- ecological sustainability;
- social welfare and equity;
- occupational health and safety;
- industrial relations and access and equity;
- economic and regional development including employment and investment growth;
- interests of consumers;
- competitiveness of Australian businesses; and
- efficient resource allocation.

Thus, NCP recognises that unrestricted competitive markets may not result in best community outcomes. However, the NCP and the legislative review process is underpinned by the view that free interactions between consumers and producers result in broadly based benefits throughout the community.

This does not mean that fewer rules and restrictions would necessarily be better. Competition itself cannot operate outside a framework of trust which is underpinned by general commercial, industrial, health and safety, and environmental laws. Some features of these laws themselves restrict actions that are deemed to undermine the operations of an efficient competitive economy.

4 The legislation and its objectives

The legislation

History of the legislation

The current act was presented to parliament in December 1994. It replaced the *Medical Practitioners Registration Act*. The act was a significant change from the previous act in that it:

- included a non-medical practitioner on the board;
- allowed for any member of the board (who is a medical practitioner) to be elected as chairperson;
- strengthened the capacity of the board to examine the conduct of medical practise and institute disciplinary action;
- updated the establishment of appeals tribunals and procedures to bring them into line with other professions and national agreement; and
- introduced a means of inquiring into the conduct of a practitioner outside of the disciplinary inquiry to deal with possibly impaired practitioners. The act also requires registered practitioners to report their treatment of another practitioner if the condition for which treatment is undertaken is considered to impair the practitioner's performance.

The act has been amended four times since it was enacted in 1995.

The main elements of the act

The act has eight parts.

- The first part consists of the title, commencement clauses and definitions.
- The second part deals with establishing the Medical Board, appointing members, including the chairperson, deputy chairperson and registrar. It prescribes their powers and functions.

- The third part of the act provides for registration of medical practitioners. It sets out the requirements for unconditional and conditional registration including qualifications.
- Part 4 of the act deals with registration — the keeping of the register, and issuing and renewal of licences.
- The grounds for complaint against a medical practitioner and processes leading to a Medical Board inquiry into the actions of a registered medical practitioner are set out in part 5 of the act. The restrictions on advertising are also contained in this part of the act, under grounds for complaint against a medical practitioner.
- Part 6 sets out the conduct of a disciplinary inquiry and the disciplinary measures that may be taken if the board makes an adverse finding. Procedures for appeal of the decisions of the board are set out. In the first instance appeal can be made to the Medical Practitioner's Appeal Tribunal which can be established as required under the act. This part also sets out the procedures for the formation of an Impaired Practitioners Committee, where the role is to ensure the competency of the practitioner.
- In addition to a number of miscellaneous provisions, part 7 of the act forbids and sets out the penalties for persons that:
  - practise without a licence
  - sue for fees for medical services if not a medical practitioner
  - hold medical appointments if not registered.

  This part of the act also sets out the conditions under which a medical company can be formed.
- Part 8 deals with transitional provisions. These preserve the existing Medical Board, Medical Disciplinary Tribunal if one is convened, the registrar, the register of medical practitioner and licences issued to medical practitioners. This part also provides for any disciplinary or other matters that were incomplete at the time of the introduction of the new act to be dealt with under the previous act.

Links with other jurisdictions

Each state in Australia has its own medical or medical practise act. All states and territories register medical practitioners and regulate the scope of their activities. Mutual recognition operates throughout Australia and New Zealand. The purpose of the *Mutual Recognition Act* is to ensure that a person registered in one or more jurisdictions would be accepted as qualified in all other jurisdictions. Medical practitioners who have obtained registration in another state or New Zealand can obtain registration in the Northern Territory by providing details and identification.

Registration under mutual recognition is half the cost of initial registration in the Northern Territory.

The legislation regulating medical practitioners varies considerably between states, not in the eligibility for registration but in the restrictions on structure and conduct. For example, Queensland and South Australia require the registration of specialists, with the qualifications set by the Colleges of Medicine. This is not required in the Northern Territory. Given the difficulties recruiting specialists in to the Northern Territory, it is felt that such a provision would magnify the existing problems, particularly in the more remote areas. New South Wales's legislation does not provide the right to practise medicine, although it precludes persons other than registered medical practitioners from providing certain specific services.

The NCP review process provides for a coordinated approach across jurisdictions to legislative reviews. While this is being followed in some areas (for example, all states and territories are adopting a coordinated approach to reviews of their respective fishing legislation), it is not being followed in the case of reviews of legislation governing medical practitioners, which are being carried out separately. It is unlikely, therefore, that the NCP review process will result in a uniform approach across jurisdictions to registration.

If a uniform approach were to be taken to the review process it is unlikely to have a negative impact on the supply of medical practitioners to the Territory. The exception would be if allowance is not made for conditional registration of persons who may not fully meet the qualification requirements but are willing and capable to fulfil specific needs in remote areas. The submission by Geoff Clark, Director of the Professional Boards, raises this issue, and suggests that the determination of the specific areas of need be determined by the Minister and not by the boards as is currently the case under section 26(2)(e) of the act. This review supports this suggestion.

Other legislation

Medical practitioners are also impacted by federal legislation — in particular, the *Health Insurance Act,* which provides for Medicare rebates for services offered on a fee for service basis. Other legislation impacting on medical practitioners are as follows.

- *Poisons and Dangerous Drugs Act.* This act limits the prescribing rights for Schedule 8 drugs to registered medical practitioners.
- *Health and Community Services Complaints Commission Act*, established in July 1998. This act set up procedures for the public to make complaints about all aspects of the health care systems, including medical practitioners. The

Commissioner for Health and Community Service Complaints has the powers of investigation, conciliation and recommendation.

- Medical practitioners are also subject to the Commonwealth *Trade Practices Act 1974*, and the Territory's *Consumer Affairs and Fair Trading Act*, which regulates advertising and business practises.

Objectives of the act

Stated objectives

The act does not state its objectives beyond the description: 'An act to provide for the registration and licensing of persons as medical practitioners and for related persons'.

The review of the New South Wales *Medical Act* suggested that the objective of the act be:

> To protect the health and safety of members of the public by providing mechanisms to ensure that medical practitioners are fit to practise.

The objectives of the act should therefore be stated explicitly.

Implicit objectives

In discussions with medical practitioners and board members the implicit objectives appear to be to:

- protect consumers from poor quality services;
- ensure confidence in the services provided by medical practitioners; and
- protect public health as poor quality services may impact on other persons through say reduced vigilance against outbreaks of disease.

These objectives of the act were supported in the submissions received. The Top End submission added to the objectives some broader purposes of the act such as keeping an accurate record of medical practitioners registered in the Northern Territory and collecting some voluntary workforce data. These could be seen as strategies to help deliver the objectives of consumer protection.

In introducing the current legislation the Minister did not address the objectives of the act beyond the need to update the legislation and bring it into line with other states and territories. The debate following the second reading speech raised several issues that provide some insight into the objectives.

- There is a perceived need to ensure not only that medical practitioners are technically qualified but that they are also socially aware of how services should be performed. This issue was raised in reference to the qualifications that are required for eligibility, as the Australian Medical Council requires additional domestic training and/or examinations for overseas trained medical practitioners.
- The government will try to get out of the way of practitioners in respect of matters such as advertising. To this end, the act allows the board to be responsible for setting the parameters for advertising under what it judges to be unprofessional conduct.
- A mechanism is considered necessary to prevent impaired medical practitioners from practicing medicine where they are considered not to be competent.

The implicit understanding evident in discussions with the Australian Medical Association (AMA) and medical practitioners was that only medical practitioners have the skills and obligations (members of the AMA are obliged to follow the AMA Code of Ethics) to provide services that are in the best interest of the consumer.

While other professions do not question the need to register medical practitioners, the lack of definition of medical or surgical service, attendance, operation or advice is seen as a possible 'Chinese wall' for the purpose of protecting the market for medical practitioners.

Key features of the act and implicit objectives

The *Medical Act* provides the right of title and the right of practice to registered medical practitioners. Only a licenced medical practitioner can practise medicine. To practise medicine is defined by the act as to 'give or perform, for a fee or reward, a medical or surgical service, attendance, operation or advice'. The act provides for penalties for those who are not licenced medical practitioners who practise medicine as so defined.

The act also sets out a disciplinary process, including warnings, impositions on conditions of registration and penalties ranging from fines to loss of licence and deregistration. These can be imposed for:

- breaches of the conditions of registration;
- a finding by the board of guilty under grounds for complaint; and/or
- a finding by the Impaired Practitioner's Committee of lack of fitness to practise.

The general reasoning behind the registration of professions and the regulation of their activities is to:

- ensure a level of competency that is adequate to protect the public from harmful practises — the right of title may be sufficient to deliver this objective, but when the cost of failure to prevent consumers choosing other service providers is considered high, the right to practise is seen as providing stronger protection; and
- convey information to the client that the person has achieved a minimum standard of training — right of title is a cost effective method of providing this information to consumers.

5 *Nature of restrictions on competition and their likely effects*

ALL LEGISLATION REGULATES BEHAVIOUR in some way, but not all regulation necessarily restricts competition. The National Competition Council (NCC), the Commonwealth body set up to advise on progress in meeting NCP obligations, has suggested seven ways in which regulation might restrict competition (NCC, *Legislation Review Compendium*, April 1997, p. 4). According to the NCC, legislation could restrict competition if it:

- governs the entry and exit of firms or individuals into or out of markets;
- controls prices or production levels;
- restricts the quality, level or location of goods and services available;
- restricts advertising and promotional activities;
- restricts price or type of input used in the production process;
- is likely to confer significant costs on business; or
- provides advantages to some firms over others by, for example, sheltering some activities from pressures of competition.

The review is required to identify the *nature* of restrictions in the act, which limit competition. Some of these may be more *potential* than *real*. For example, registration potentially limits market entry, but if it is used solely to require certain standards for market participants and is not used to limit their size or numbers, it should not be considered to have any actual impact on market entry.

The actual impact of each restriction on competition or potential restriction on competition needs to be assessed prior to any evaluation of the balance between benefits and costs to the community.

Efficient competition cannot take place in a totally unrestricted way but requires a body of laws which set the rules in terms of property rights, the types of commercial and industrial relationships permitted, and obligations within commercial relationships for health and safety and for the environment. Indeed, part IV of the *Trade Practices Act 1974* (which is an integral part of NCP)

prohibits a range of actions which, while they might otherwise be used by individual market players to promote their competitiveness, are considered anticompetitive in an economywide context.

A competitive industry is generally considered to be one in which:

- there are no restraints on firms or consumers entering or leaving the industry;
- there are no constraints on the free flow of information between suppliers and consumers; and
- prices paid and received for the industry's outputs and inputs are determined by the independent actions of many supplies to and consumers in the markets for those services.

The *Medical Act* contains a number of regulations that could be classified as restricting or potentially restricting competition under several of the headings used by the NCC as follows. The restrictions on market structure come from restrictions on entry and exit. There are also a number of restrictions on the conduct of medical practitioners that are potentially anticompetitive. They fall into a further three of the seven areas identified as restrictions on competition in that they restrict advertising and promotional activities, restrict the quality, level or location of goods and services available and/or restrict price or type of input used in the production process.

Restrictions on entry and exit

Restrictions on entry and exit are the main restrictions that impact on the structure of the market. The restrictions imposed by the *Medical Act* that impact on market structure — in particular, those that limit the supply of medical services available — fall into this category.

Registration requirements

To be registered a person must make an application to the board, pay the application for registration fee, and appear before the board to demonstrate their eligibility.

Registration and license fees

The cost of initial registration and license is $300, unless registered under mutual recognition in which case the cost is $150 for a licence. The annual licence renewal cost is $150. The Clark submission notes that this cost is tax deductible.

While this sum is unlikely to deter entry for medical practitioners moving for a long period of time to the Northern Territory, it may deter a short visit to provide specialist services or locum arrangements, a view supported in the Top End submission.

Qualifications

The qualifications for general registration are set out in section 24 of the act. A person is qualified for general registration who:

- immediately before 1 January 1993, held both the degrees of Bachelor of Medicine and Bachelor of Surgery or equivalent degrees of a medical school of a university in Australia or New Zealand;
- graduated in a course of study approved by the Australian Medical Council from a medical school so approved; or
- has successfully completed the relevant examinations conducted by the Australian Medical Council.

As noted in the Clark submission, completion of an approved course includes any period of clinical training required. The Top End submission raises an issue with a current proposal to allow overseas trained doctors to have temporary registration. The submission expresses concern that such a move may restrict training access for Australian GP Registrars due to the limited supply of training places.

Eligibility

Potentially anticompetitive elements of the requirements for eligibility (section 27(2)) are:

- qualifications for general registration;
- completion of a period of approved internship or approved supervised training;
- good fame and character;
- adequate command of the English language; and
- resides, or intends to reside in the Northern Territory.

Just what is good fame and character is not defined in the act.

The Clark submission suggests that fitness to practise and competency to practise replace good fame and character.

Fitness to practise would include:

- adequate physical and mental health;

- absence of relevant convictions for indictable offences, statutory offences relating to the professional's practise, and findings of guilty in either civil or disciplinary proceedings in any jurisdiction; and
- absence of relevant current criminal or disciplinary investigations in a foreign jurisdiction.

Competence to practise would include:

- English proficiency
- evidence of continued competence as a practitioner.

A requirement of evidence of continued competence is not present in the current act. This provision is important in the act achieving its objective. The need for such a provision is discussed later.

The requirement to reside in the Northern Territory potentially restricts the supply of medical practitioners, particularly to remote areas, which are usually visited on a rotation basis. The act precludes medical practitioners based in another state from providing such services unless registered in the Northern Territory. The issue is not so much the fee for registration as the time it takes and the administrative costs.

The Top End submission points out that there may already be an issue with some new programs that are managed from outside the Territory such as the Fly In and Fly Out Women's General Practice Service, which is contracted to the Royal Flying Doctor's Service of South Australia. The Clark submission points out that the provision is not consistent with the Mutual Recognition Principles or NCP Agreement.

Right to practise

The act restricts the right to practise medicine defined as to 'give or perform, for a fee or reward, a medical or surgical service, attendance, operation or advice' to licenced registered medical practitioners.

Section 56(1)(a) states that a person, other than a registered medical practitioner to whom section 29, 31(1) or 34(3) applies shall not practise medicine, unless he or she holds a current licence. The penalty is $25 000 or imprisonment for five years. The exclusion provisions cover persons with interim registration (29), those who have applied for a licence (31(1)), and the period allowed for renewal of licence prior to cancellation of registration (34(3)).

To hold a current licence a person must be a registered medical practitioner.

This restriction is clearly anticompetitive in that it prevents any person other than the licenced, registered medical practitioner from providing medical services for a fee. The only difference between this provision and that restricting the right to practise nursing in the *Nursing Act* is that practising medicine is defined in the act as medical or surgical services provided for *fee or reward*, while nursing practises are not defined in this way.

A further difficulty arises in the definition of what services, advice or attendance constitute medical practise. The act does not attempt to define what is medical practise, leaving it to the discretion of the board and case law. The Clark submission raises two problems with statutory definitions. The first is the difficulty of defining practises that do not overlap with the legitimate scope of other professions. The second problem arises when another professional group may legitimately claim competence to perform the activity. Added to these is a third problem of the continuing evolution of medical practise, so a relevant definition is likely to become rapidly obsolete.

This section of the act also prohibits medical practitioners registered in other states or territories from practising in the Northern Territory. They are also prohibited by the residency requirement from registering in the Northern Territory. Exceptions to the right to practise are allowed for medical practitioners who are entitled to practise medicine in an other state or territory for:

- the purpose of escorting a patient to or from the Northern Territory;
- the purpose of a surgical operation, being organ retrieval and transplant by a member of an organ transplant service recognised by the hospital at which the operation takes place;
- the purpose of participation in neonatal or adult intensive care transfers;
- the purpose of compliance with a law in force in the Northern Territory;
- the purpose of proceedings in a court; or
- in the case of emergency.

This restriction would also appear to prohibit providing medical services to Northern Territory customers by phone, fax or email from suppliers outside the Northern Territory (telemedicine).

The Top End submission raises the issue that, regardless of who provides the advice, the medical practitioner delivering the service has the responsibility for the outcome. The AHMAC is currently considering the issue of 'telehealth' services from a national perspective. The Clark submission makes the recommendation that the issue be deferred until the AHMAC decision has been received.

Right to title

The act restricts the use of the title 'medical practitioner' to registered medical practitioners.

Section 56(1)(b) and (c) state that a person other than a registered medical practitioner to whom section 29, 31(1) or 34(3) applies shall not:

- hold himself or herself out as being, or in any manner pretending to be, or take or use the name or title (alone or in conjunction with any other title, word or letter) of physician, doctor of medicine, licentiate in medicine or surgery, master in surgery, bachelor of medicine or surgery, doctor, surgeon, medically qualified, registered or licensed practitioner, or other medical or surgical name or title: or
- hold himself or herself out, directly or indirectly, by a name, word, letter, title or designation, whether expressed in words or letters, or partly in one and partly in the other, either alone or in conjunction with any other word or words, or by any other means, as being entitled or qualified, able or willing to practise medicine unless he or she holds a current licence.

The penalty is the same as for a practise violation — $25 000 or imprisonment for five years.

A related provision (section 58) is that a person other than a registered medical practitioner shall not hold appointments as a physician, surgeon or other medical officer in a hospital or public institution for affording medical relief, a health, welfare, natal or industrial clinic, a prison, or as a medical officer of health within the meaning of the *Public Health Act*. The penalty is $10 000.

This provision effectively restricts the use of these titles in these types of institutions to registered medical practitioners.

Right to recover fees

The act restricts any person who is not registered from using the court system to recover fees charged for medical services performed.

Section 62(2) states 'a person who is not a medical practitioner cannot sue or counter claim, set off or recover a charge for a medical or surgical advice, attention, service or operation or for any medicine prescribed and supplied'. The penalty for such an action is $5000.

This restriction means that anyone who is not a registered medical practitioner cannot recover bad debts for medical services performed. The justification would be that this would strengthen the consumer's ability to respond to inadequate or

poor service by not paying the fee. The provision is incongruous, as it is illegal for a person to charge a fee for the supply of such services. The Clark submission agrees that this provision is redundant given the restriction of title and right of practice.

Restrictions on advertising

Section 38 of the act allows for a person to make a complaint in writing to the registrar against a medical practitioner on a number of grounds. Most deal with competency (fitness to practise) but subsection 1(h) provides ground for complaint on the grounds that the person is guilty of any other unprofessional conduct. Subsection 2 states that, for the purpose of subsection 1(h), unprofessional conduct includes:

- the practise of advertising to procure patients or to increase a practice, or sanctioning or being associated with or employed by a person who sanctions such an advertisement; or
- the practise of canvassing or employing an agent or canvasser to procure patents or to increase a practice, or sanctioning or being associated with or employed by a person who sanctions such canvassing or employment.

The Clark submission argues that the effect of this provision is to essentially place control on:

- the type, size, style and content of advertisements; and
- the frequency with which advertisements may be made.

This provision is strengthened by section 55, which makes it an offence to directly or indirectly contribute to unprofessional conduct, by a medical practitioner. The penalty is $10 000.

Such provisions limit the commercial activities of medical practitioners, and may result in reduced information for consumers. The Clark submission also raises the issue that some professional boards have been required to devote inordinate amounts of time and resources to implement and monitor these provisions.

It has been suggested that such restrictions are necessary to ensure ethical conduct in the industry. The restrictions are said to prevent misrepresentation of benefits of services, helping to prevent overservicing and the provision of services that are potentially damaging to the consumer. Medical practitioners who advertise in a false or misleading way could be prosecuted under the *Consumer Affairs and Fair Trading Act 1990*, which establishes procedures and penalties for such behaviour. However, there is concern that only major transgressions would be deterred by

trade practices legislation, while the board can address even minor infringements easily and at low cost.

Restrictions on the quality, level or location of goods and services available

Grounds for complaint against unprofessional conduct

The open nature of the definition of unprofessional conduct in section 38(1)(h) could allow for restrictions on the quality, level or location of goods and services available. For example, if it were deemed unprofessional to establish a doctor's surgery in a shopping centre, this would limit the choices available to consumers, who might find this location convenient.

The Clark submission reports that there is abundant case law on what constitutes unprofessional conduct. The general principles that have evolved from this law are that misconduct is a departure from accepted practises where such a departure would be critisised by fellow practitioners of good repute and competence. The submission makes the case that the board, which includes a majority who are representatives of the profession, and is answerable to the Minister, is the most appropriate body to determine what constitutes unprofessional conduct, with a safety net review provided by the court.

Given that there is ample case law to determine a definition of professional misconduct the section provides protection for the public and the opportunity for any practitioner undertaking innovative or new practises to defend that practice in the courts. As a result, the provision is not considered to be anti-competitive. It is also considered that the board is the most appropriate body to determine what constitutes unprofessional conduct, with its majority being made up of members of the profession.

Restrictions on price and type of input used in the production process

Section 54 of the act contains a number of regulations about the structure and operation of medical companies.

- Section 54(1) states that a medical practitioner may, with one or more other medical practitioners, form a medical company by incorporation under the Corporations Law.

- Section 54(2) states that an individual medical practitioner may, with one other person who is not a medical practitioner, form a medical company by incorporation under the Corporations Law.
- Section 54(3) states that a medical company shall not be incorporated except under a constitution and a name approved by the board. Nor can it alter this name of constitution (4), and (5) the board can request a medical company to make reasonable alterations within a reasonable time to its constitution and the medical company shall comply with the request. A company that does not comply with the request is guilty of an offence (6) for which the penalty is $5000.

The first two subsections, together with the requirement that a medical company be approved by the board (7) effectively limit the form of a medical company. The section also imposes a number of unspecified restrictions on the conduct of a medical company. These may impose additional costs on the company.

The Clark submission reports that the argument in favour of these provisions is that they protect the public from the unethical practises of non-health practitioner if such persons are allowed to own health practitioner businesses. However, the submission goes on to argue that evidence has shown that such protection is illusionary in that unethical and fraudulent behaviour occurs in health practitioner businesses owned by health practitioners. The submission cites as evidence the level of prosecution of medical practitioners for medifraud.

6 *The balance between costs and benefits of restrictions*

IN ITS ASSESSMENT OF THE BENEFITS AND COSTS of the various restrictions on competition which are apparent in the *Medical Act*, a key issue is whether market failure in the provision of medical services justifies the various restrictions. Unrestricted markets might fail to deliver best community outcomes if:

- benefits flow to sectors of the community which do not contribute to costs or costs are imposed on those who do not receive benefits (externalities);
- information available to one group is not available to others with whom they do business (information asymmetry);
- economies of scale are so large that only one provider would survive in the market (natural monopoly); or
- goods and services are provided in ways from which no potential user can be excluded (public goods).

The existence of externalities and the presence of information asymmetry are key considerations behind some of the restrictions that are routinely included in health acts.

Benefits

The benefits of any restrictions on competition in the Northern Territory medical practice industry need to be assessed with respect to the stated or implicit objectives of the legislation. With no stated objectives, the implicit objectives — to protect the health of the Northern Territory public by ensuring that only those persons suitably qualified to practise medicine are allowed to undertake it — becomes the benchmark against which the legislation should be assessed. In addition, the overriding objective of NCP itself, which is to encourage efficiency by means of a more competitive economy, must be considered, as should the public interest issues nominated in the NCP agreements — namely, the environment, employment, regional effects, consumer interests as well as the competitiveness of business.

The fundamental justification for government intervention in professions is market failure due to asymmetric information and externalities. Asymmetric information arises when consumers do not generally have the training or capacity to judge the quality of a service. Services that are highly complex, have long term rather than short term outcomes, are rarely purchased and have a low cost are those where asymmetric information is greatest. This is because it is difficult for a consumer to assess the likely outcome, and where costs are low they also have little incentive to do so.

The costs of asymmetric information are directly related to the costs of poor service. Where poor or incompetent services impose a high cost on individuals and/or the public the costs are high. They are potentially very high when it comes to services provided by medical practitioners. This is due both to personal costs — pain and suffering that might be associated with poor quality outcomes — and financial costs to rectify the problem.

Externalities occur when the services provided to a consumer result in impacts on other consumers. It is widely accepted that the community as a whole benefits from improvements in the health of its citizens. And public health can be threatened by failure to isolate and adequately treat contagious diseases. With the publicly funded nature of the Australian health care system, costs of addressing the consequences of poor services are also likely to fall to a great extent on the general public.

Registration and right to title requirements for medical practitioners can be seen as providing valuable information to consumers on the capabilities of the service provider. The right to practise may be necessary to ensure that only persons trained as medical practitioners provide services that in the hands of less qualified persons would impose significant risk of harm to a consumer's health.

Restrictions on company structure may prevent non-medical owners of companies from exerting pressure on the medical practitioners providing the services to 'cut corners'. This in turn may help ensure that services are carried out professionally, minimising the risk to consumer health, which is of benefit to consumers and society as a whole. The restrictions may also reduce over servicing, to the benefit of the general community who meets most of the cost of medical services through taxes. However, there is no evidence to support these possible benefits.

Costs

Costs of the restrictions to medical practice and to the community can be of several types:

- administrative, enforcement and compliance costs

- efficiency losses
- imposts on consumers.

Unlike the situation in most other Australian jurisdictions, professional regulation in the Northern Territory is not self-funding. Annual registration fees charged do not cover the cost of the board's administrative and enforcement activities. It is estimated that the Northern Territory government, through THS, currently contributes about $350 000 per year to the operation of all professional boards. The community as a whole, through the budgetary process, picks up this bill. Annual registration fees, although borne in the first instance by professionals, are likely to be passed on to consumers in fees charged.

This is also likely to be the case with compliance costs. Companies through the restrictions on their structure may bear higher costs such as administrative, insurance and financing costs.

The regulations are also likely to involve some efficiency losses in the way services are provided to consumers. The main issue comes with the restriction on practise. What constitutes 'practising medicine' is not defined by the act. This may make the restriction more or less binding than would an explicit definition included in the act. In practice, leaving the definition to the board has worked well as medical practitioners have allowed nurses to perform more services where they have demonstrated competence to do. Nurses may still be excluded from receiving the Medicare fee for the service performed, and so must perform such services under the auspices of a medical practitioner, however, this is not an issue impacted by the *Medical Act*.

Nethertheless, if the board chose to take a broad view of the definition of medical practise, other health practitioners, who are competent to perform some medical services, would be precluded from doing so. As a result, the consumer may have less access to medical services and be paying more for such services due to the restriction on right to practise enforced by the act.

Nurse practitioners and primary health workers now provide many of the services that are considered in Australia to be practicing medicine. There is considerable interest in encouraging the profession of nurse practitioner in Australia and in the Northern Territory. The justification behind this interest is the comparatively lower cost of providing some medical services and the likely greater availability of nurse practitioners to work in rural and remote areas.

Given the public funding of the main share of medical services, the impact of the legislation on public funds must be considered. The federal government is a major purchaser of the services of medical practitioners through Medicare. If the act limits the number of medical practitioners, claims on Medicare are reduced.

However, for the Northern Territory government, a reduced supply of medical practitioners will tend to raise the salaries needed to attract staff, raising costs. Similarly, for private services purchased by consumers, the fee for service may be higher if there is a restriction in the supply of medical practitioners.

Balance between benefits and costs

The following assessment considers in turn the balance between benefits and costs of each of the potential restrictions on competition identified in the previous chapter.

Registration fees and qualifications

The act sets out the requirements for registration, which includes:

- payment of a registration and licence fee (totalling $300 a year)
- qualifications
- eligibility which sets out, among other things:
  - good fame and character
  - medical fitness
  - English competency
  - residency, or intent to reside, in the Northern Territory.

Licence and registration fee

The benefits of the registration and licence fee are that they prevent frivolous application for registration, which can occur when services are offered for free. They also go some way to covering the cost of the administration of the register and the administration of the board.

As noted earlier, the magnitude of the fee, and the compliance costs involved in payment of the fee are not substantial, and are tax deductible. Concern was expressed in the Top End submission that the fee might inhibit short term entry for medical practitioners providing locum or other short term services. It was argued that mutual recognition and development of uniform criteria for registration should facilitate the short term exchange of medical practitioners. There would be substantial benefits to the Northern Territory from enhancing this exchange both for training purposes and ensuring availability of suitably trained replacement staff.

As the fee in part covers the cost of administering the disciplinary process as well as the register, it is appropriate that those generating their income in the Northern

Territory fund it. The suggestion that the fee be pro rata in the Top End submission has appeal, but the benefits must be offset by the increased administrative costs this would entail.

Relative to fees for services and salaries the fee does not appear to constitute a barrier to entry.

Qualifications

There was no issue in the submissions with the nature of the qualifications required for registration. They were considered to be necessary and sufficient for right to title. Discussions with medical practitioners and the board raised the issue of whether the qualifications need to be spelled out in the act. Section 24 sets out the eligible qualifications, which are determined by the Australian Medical Council (AMC). If the AMC decisions exclude certain qualifications that are sufficient for competence, the board may be prevented from granting registration to persons whose qualifications are, in the board's view, sufficient for eligibility.

The benefits of a board made up predominantly of professionals determining the professional requirements for registration are likely to exceed the costs. The basis for such determinations is likely to be the completion of an approved course of studies from an institution which is externally accredited and backed up by an appropriate period of supervised practice, and this is also likely to be a basis for membership of a professional association.

However, the costs of the professions themselves determining their own qualification requirements for registration potentially could exceed the benefits, or might be perceived to do so by the public which the boards are meant to protect. A net public benefit can only be assured if the boards unequivocally are required to serve the public interest and are seen to have an independence from the academic institutions and professions. This should be incumbent on all board members. Under section 26 the board has the right to take public interest into account and whether a person is suitable to meet a community need in granting conditional registration.

The Clark submission provided an approach to qualifications that addressed the needs of the Northern Territory and should address the concerns about overseas-trained doctors seeking temporary registration. This was to allow conditional registration of medical practitioners meeting areas of specific need, who might not otherwise be fully qualified for registration. Areas of specific need could be determined only by the Minister and not by the board. Given the difficulties in re-cruiting medical practitioners to remote areas and the often special needs of the indigenous population, such a provision would improve the Northern Territory's capacity to provide adequate services to all it's residents.

Section 24 should be revised to allow eligible qualifications to be determined by the board.

The act should provide for conditional registration of persons for employment in specific needs areas as designated by the Minister for Health.

Eligibility

The good fame and character provisions, plus the other criteria for eligibility preventing persons of known criminal and other relevant conditions from registration, are part of the assurance provided to consumers by registration. The benefits of these provisions are that they protect the community from professionals of known bad reputation. Requirements for English and to be medically fit exclude those that are liable to impose damage due to their inability to deliver a competent service due to communication or physical inadequacies. Such outcomes would also damage the reputation of the profession, with loss of public confidence.

The cost of such provisions is that they could potentially be used to preclude entrants from the profession. Unless the criteria are applied consistently there may be discrimination against particular persons. This can come about because good fame and character is not defined.

Confidence about a net public benefit from continuing with fitness to practise restrictions is likely to remain questionable for as long as concepts such as 'good fame and character' and 'unprofessional conduct' remain vague in the public mind. The Clark submission pointed out that there is abundant case law to guide the board on these matters. However, it is proposed that any future legislation should include a fitness to practise requirement, using the wording in the Clark submission to include:

- adequate physical and mental health;
- absence of relevant convictions for indictable offences, statutory offences relating to the professional's practise, and findings of guilt in either civil or disciplinary proceedings in any jurisdiction; and
- absence of relevant current criminal or disciplinary investigations in a jurisdiction outside of the Northern Territory.

These words appear to be sufficiently clear to preclude any anticompetitive or otherwise inequitable treatment criteria being used under a fitness to practise requirement, and hence would enhance confidence about them being in the public interest. The mandatory reporting of any change in status on these matters, with power by the boards to act on that information would also underpin their effectiveness.

A requirement unique to the *Medical Act* is that medical practitioners must reside or intend to reside in the Northern Territory to be eligible for registration. All discussions and submissions indicated that this provision has no benefit and may impose costs in terms of limiting personnel available to work in rotation in remote areas. There is uncertainty about whether this provision has been enforced in the past.

'Good fame and character' requirements should be retained, with explicit definition of what is means included in the act. A right of appeal should be allowed.

The requirement for residence in the Northern Territory (section 27(2)(e)) should be repealed.

Right to title

The act provides for only registered medical practitioners to be entitled to use the title medical practitioner. Unregistered persons are prohibited from using the title or close variants as set out in section 56(1)(b), and a penalty applies to false claims or representing oneself as entitled to use the title.

Benefits

The main benefit of the right to title is the information it provides to consumers. This information is dependent on the requirements of registration. Under the current *Medical Act* these include:

- attainment of a minimum standard of qualification and practical training that is considered by those in the profession to be sufficient to provide skills for competency; and
- fitness to practise in that the person:
  - is not suffering from a mental or physical disability that prevents them from practising medicine efficiently,
  - is judged to be of good fame and character, and
  - has not been successfully prosecuted for any misdemeanor or crime that impacts on their trustworthiness or capacity to deliver medical services.

This is information that the consumer could not easily be able to confirm and hence the registration procedure improves confidence in the quality of the services provided.

Consumer confidence in the current competency of a registered medical practitioner is further enhanced by the knowledge of a disciplinary procedure that

allows incompetent practitioners to be directed to improve services or prevented from continuing to provide services.

Consumer confidence in the services is important to ensure that people seek medical attention when sick. Early identification of communicable diseases as well as early intervention and prevention improves public health and reduces the overall cost of health care. As the public fund a majority proportion of health care delivery in Australia, such confidence helps to reduce the overall cost of delivering health outcomes for the taxpayer.

Registration and right to title also promotes the average quality of service and hence health outcome through:

- reducing the likelihood of consumers selecting persons not competent to provide those service; and
- raising a sense of professional identity and hence supporting overall standards.

Right to title is of greatest benefit where title implies competency to practise. While the board can currently ensure competency when an applicant applies for registration, and has processes to identify professional misconduct by registered medical practitioners, there is no requirement in the act for continuing competency checks. The information conveyed by right of title would be strengthened by some form of continuing competency requirement enforced by the board.

Medical practitioners are encouraged to keep up to date through the scale of fees set by the Medicare Benefits Schedule, which will compensate practitioners for services at a higher rate for demonstration of additional training. The AMA also encourages its members to keep up to date. There is an accreditation procedure in place that many practitioners participate in.

The Clark submission sets out a strong case for requirements for demonstration of continued competency. The Quality in Australian Healthcare Study (Australian Health Ministers' Advisory Council 1997, *The Final Report of The Taskforce on Quality in Australian Health Care*, June) highlighted failures in technical skills as being a key contributor to adverse events. It emphasised the need to ensure individual practitioners maintain their competence over time.

The case for continued competency tests is one in which public benefits appear to exceed costs. However, without specifying how such competency tests are to be implemented, costs, and indeed benefits, cannot be determined. The costs of tests are not only the administrative costs, but also the compliance costs as practitioners have to take courses, pass exams or undertake other forms of testing. The benefits too will depend on the tests and whether they reflect competence in practise.

The right to title may also reduce the cost of professional indemnity as it removes the need for insurance companies to check qualifications and monitor professional

activities lowering their costs, which should be passed on in lower premiums than would otherwise be the case. To the extent that the quality of services is improved, with associated lower claims, premiums should also be lower. This lower cost to practitioners should be reflected in lower fees than would otherwise be required.

If the Northern Territory were not to retain registration and the right to title, there is a risk that those practitioners who had been refused registration in other states or territories or others wishing to represent themselves as medical practitioners might take advantage of this difference. This would be to the detriment of the public in the Northern Territory.

Costs

The costs of the right to title are minimal and consist mainly of administrative costs. Administrative costs include the costs of:

- checking qualifications and eligibility
- administering the board and disciplinary procedures
- registration fees
- compliance for the practitioner.

There are no anticompetitive elements of substance in the right to title. The regulation does not prevent entry to anyone who meets the registration requirements. It does not prevent anyone who is not registered from providing services.

Assessing the balance

The once off nature of the costs of checking, as opposed to repeat costs if consumers had to seek this information, is clearly much lower. The cost of administration of the board and disciplinary procedures is small in comparison to the benefits of an effective quality control mechanism.

The current registration fees do not cover the cost of administering the board. The public makes up the shortfall through budget support by THS. While the benefit to the public is clearly in excess of the required budgetary supplement, a case can also be made for the profession to bear more of the cost of the administration of the act. The improvement in consumer confidence and hence demand for services provides for greater employment opportunities in the profession. The enforcement of minimum standards of conduct by registered practitioners is of considerable benefit to all practitioners as it helps maintain confidence in the profession, as well as possibly lowering indemnity insurance costs. Compliance costs for the professional for right of title are minimal, and fees are tax deductible.

The public benefit clearly exceeds the cost of the public funding of the administration of the board. The professional benefit is also judged to be greater than the current contribution to the board administration and compliance costs.

The protection of right of title is consistent with the legislative approach that has been successfully trialed in Ontario, Canada (Clark submission).

Right to title (section 56(1(b)(c))) should be retained. The act should require demonstration of continued competency for renewal of licences. The board should move to raise registration fees to allow for greater cost recovery for administrative costs

Right to practise

The act makes it an offence for any person who is not a registered medical practitioner and holds a current licence to practise medicine. Exceptions are allowed for medical practitioners registered in other states or territories to undertake prescribed services, mainly associated with patient transfer into or out of the Northern Territory (section 56 (2)).

Benefits

The main justification for the restriction of right to practise is that it is necessary to protect the public from incompetent treatment. There are two issues of importance on which the validity of this claim rest.

- Are medical practitioners the only health practitioners who can provide medical services that meet the high minimum quality standards demanded by the Australian public?
- Are there a set of persons who would sell medical services that would threaten public health and would consumers purchase services from these persons, given that they would not be entitled to a Medicare rebate for the cost of the service?

The Top End submission addresses the first question. They argue that

> ...to allow wholesale provision of medical services by persons other than a medical practitioner could be an unmitigated disaster for consumers by allowing State and Federal Health Departments to abrogate their responsibilities to provide adequate health infrastructure and continued support for medical practitioners.

While this does not imply that other health practitioners are not able to support some medical services, there is a concern that less than the full range of services might be provided, especially in remote areas, by employment of other health practitioners in what are currently medical practitioner positions.

The second question is difficult to answer in an informed manner. While there are estimates of the cost to public health of incompetent practice by medical practitioners, there are no equivalent measures of the cost of incompetent medical practice by those who are not registered as medical practitioners. That such costs could be substantial is not to be denied. The issue is whether consumers are sufficiently informed and other legislation dealing with fair trading and health complaints are sufficient protection from these costs.

The benefit of protection from incompetent treatment are the avoidance of personal costs borne by those receiving the treatment, and the public cost of providing further treatment to address the consequences of the incompetent treatment. In the case of communicable diseases these may be substantial. These benefits must be weighted by the probability that removing the right of practise would increase such incompetent treatment.

Costs

The main cost of right to practise comes from exclusion of other health practitioners from practicing what they may have been trained to practise. This reduces competition for the provision of these practices, with resulting higher prices and reduced access for consumers. Higher prices impose direct costs on consumers and other purchasers, while reduced access may increase long term health costs, much of which is borne by the public purse. The Clark submission makes the claim that:

> ...such restrictions are prima facie anticompetitive, and unless they can be shown to be absolutely necessary for the public's protection, it is arguable that they serve only to protect the interests of the relevant professions.

The counter to the argument that other health practitioners might be used to replace medical practitioners at detriment to consumer welfare and public health is that for areas which are not currently able to support a medical practitioner, presence of another health practitioner who can provide some of the medical services, which they have been trained to provide, is a better outcome. The provision of right to practise in this act may prevent this. Currently, most medical practitioners are happy to support the provision of services, which might be construed as 'medical services', by nurses or other health professionals where they are competent to provide the services. Medical practitioners may be called on to provide advice in the delivery of such services, and this linking of professionals has proved to be an effective method of improving services in remote areas.

Assessment of balance

There may be certain medical practices that no other health practitioner other than medical practitioners have been trained to provide. There may also be certain practises that if incompetently performed pose a high risk of substantial private and/or public costs. If these practices cannot be assessed prior to purchasing the service, and if the competence of the practitioner to deliver these services cannot be assessed by the purchaser before or after the service, then there is a case for restricting the practise to those qualified to perform the practise. Other than in these circumstances no case can be made for a benefit from right to practise additional to that achieved by right to title.

What should constitute a restricted practice area should be left to the discretion of the board rather than enshrined in legislation. Given the rapid advance of medical science, practices, which fit this description at the current point in time, may not do so in the near future. This point is made well in the Clark submission.

> Health service delivery occurs in a rapidly changing and developing society and that, in concert with society, professions also evolve, treatment modalities change, and new professions emerge. It is imperative that any new legislation not just meet the challenges now but be flexible enough to accommodate the changes that will occur in the future.

Whether restricted practice areas need to be defined by the board depends on the probability that a person who is incompetent will provide them. It is unlikely, for example, that a person, who is not a medical practitioner, would attempt open heart surgery. And a registered practitioner who was not trained in this area would risk the charge of professional misconduct if they performed such a service. In the NCP review of the New South Wales *Medical Act* it was recommended that the few areas, such as treatment of cancer, which are designated as restricted practice areas, be removed. The justification was that they were not effective in preventing public harm, and that there was other legislation that better protected the consumer.

The provision (section 56 (1)), which can be interpreted to provide exclusive right of practice, should be repealed.

The board should be given the right to declare restricted practice areas that are limited to medical practitioners and others who the board considers are trained to practise, but they should have to justify the public interest in imposing such restrictions on practise.

Right to recover fees

The right to recover fees is limited to registered medical practitioners. This right was redundant given the right to practise, as it was an offence to provide a medical service for a fee or reward.

Benefits

The benefit of this provision is a deterrent for health practitioners other than medical practitioners from providing medical services. Any benefits are similar to those under right of practise.

Costs

With the recommendation of the removal of the right to practise this clause remains a barrier to the provision of medical services by those other than registered medical practitioners. By raising the costs of practice for unregistered practitioners (due to a higher probability of bad debts) it gives unfair advantage to registered practitioners.

Assessment of balance

Retaining this provision while not retaining right to practise is incongruent, and would impose higher costs on consumers of the medical services that might be offered by health practitioners other than medical practitioners.

The section that precludes unregistered practitioners from the right to recover fees (section 62 (2)) should be removed from the act.

Unregistered persons not to hold medical appointments

This element of the legislation is very similar in nature to the right to practise. Where employers feel that registration is required for competent performance in the appointment, they can make this a condition of employment.

Benefits

There are no apparent benefits to including this requirement in the *Medical Act*.

Costs

The costs are the exclusion of persons who may be fully qualified for the position but who do not meet the requirements for registration.

Assessment of balance

The requirement for unregistered persons not to hold medical appointments (section 58) should be repealed.

Restrictions on advertising

The act makes it an offence to engage in or to assist a medical practitioner to engage in unprofessional conduct. The act explicitly lists unprofessional conduct as including the practise of advertising to procure patients, or increase a practice, or employing someone else to do so.

Benefits

The benefits of this provision are difficult to identify as they are preventative in nature. For the public financiers of the health system there may be some benefit, in that lack of advertising might result in lower demand for services. The restriction may also deter less reputable providers from establishing practices, given that attracting clients relies more on word of mouth and reputation than clever advertising.

The most commonly cited benefit of this section of the act was that the provision prevents false or misleading advertising that would be of detriment to the public. Other legislation is not seen as being sensitive enough to effectively prevent abuse of advertising by medical practitioners.

Costs

Advertising supplies considerable information to the consumer, so this restriction reduces information. New entrants are at a disadvantage as it is difficult for them to widely inform consumers of the availability of their services.

The Clark submission noted that:

- these restrictions prevent health practitioners from operating their practices in a commercial manner — which may result in higher costs for consumers;
- monitoring the provision can be very time consuming for the board; and
- there is adequate protection from false or misleading advertising in the *Consumer Affairs and Fair Trading Act*, although the submission recognises some validity in the difficulty of pursuing small matters of false and misleading advertising through this avenue, and the potential high costs of such advertising.

Assessment of balance

The value of information denied to the consumer is judged to be considerably greater than the doubtful benefit of prevention of overservicing that might arise as a result of advertising. False or misleading advertising is professional misconduct and does not need to be separately listed in the act (see below).

Section 38(2) of the act, which includes advertising as a component of professional misconduct, should be deleted.

Restrictions on price and type of input used in the production process

Businesses that provide medical services are restricted in their ownership and company structure. A medical company may be owned by a group of medical practitioners, or a medical practitioner with one other partner. The constitution of the company and its name are subject to approval by the Medical Board.

Benefits

The claimed benefit of these requirements and restrictions is that they prevent persons who are not medical practitioners from lowering professional standards of service delivery in the pursuit of profit. No case has been presented for these threats to be a real concern that would infringe on public benefit.

Costs

These restrictions limit the access to capital and business expertise with the result of higher costs and poorer overall conduct of medical business. The Clark submission supports this conclusion:

> Evidence has shown that such protection is illusionary in that unethical and fraudulent behaviour occurs in health practitioner businesses that are owned by health practitioners. Th level of prosecution for medifraud is a clear example of this.

The submission goes on to point out that *Corporations Law* provides for sufficient public protection with stiff penalties for illegal conduct. However, a concern of medical practitioners is that they would be forced by owners, who are not medical practitioners, to engage in unethical behaviour. To address this concern, the submission suggests that a provision be included to make it an offence for a company or its employees, agents or directors, to engage in conduct that results in or is likely to result in, undue influence on a health practitioner employed in the provision of health services to the public by the company.

Assessment of balance

On balance, the social cost of these restrictions is likely to exceed the social benefits.

All restrictions on ownership of medical companies, and requirements for board approval of the constitution and company name (section 54) should therefore be repealed.

7 *Alternative ways of achieving objectives*

NCP REVIEWS ARE REQUIRED to consider whether there are alternative means for achieving the same results as those which restrict competition, including nonlegislative approaches. The key question is whether the implicit objective of the act — that only those persons suitably qualified to undertake professional health care are allowed to undertake it — can be achieved efficiently and effectively, but in less regulatory ways than at present.

The issues paper invited interested parties to comment on this proposition and to suggest less regulatory ways of delivering safe and high quality health care to Northern Territory service users.

There is a range of alternatives, perhaps less costly, mechanisms that might be considered to achieve the act's implicit objective of protecting the health of the Northern Territory public. These include:

- providing enhanced information to consumers, including official warnings, advertising campaigns and publication of pamphlets about specific professional and occupational services;
- listing or certification schemes which require practitioners to inform a central authority about educational qualifications and previous experience in the industry as a substitute for the specification of allowable practises; and
- so-called negative registration where service providers are not screened before starting practice, but only prohibited from practising if shortcomings in their operations are identified.

These alternatives have traditionally been rejected in the case of most professionals providing health services. None of the submissions received responded to these alternatives. Nor were any of them advanced in discussions as being likely candidates for practical, less costly alternatives to the registration procedures assessed in the preceding chapter.

Other issues

Interested parties were invited to respond in this review to any other aspects of the *Medical Act* or the way in which medicine is practised are regulated in the Northern Territory that is of concern for them.

Medical specialties

The Northern Territory act does not require the registration of specialists, as is the case in some other jurisdictions. This has been of benefit to the Northern Territory in being able to employ specialists that may not completely fulfil the requirements of the colleges for recognition as a specialist. However, for specialists to be able to access the speeialist Medicare rebate they must be registered with the medical colleges. This was seen by a number of respondents as anticompetitive, especially when combined with limits on entry to the colleges.

While this is not an issue for the Northern Territory *Medical Act*, it was a major concern that many wanted to see flagged as of considerable detriment to the competition in the provision of medical services.

8 *Recommendations*

THE FINAL TASK FOR THIS REVIEW is to make clear recommendations which flow from the foregoing analysis. A requirement of the terms of reference is that if change is not recommended and restrictions on competition are to be retained, a strong net benefit from retention must be demonstrated.

An overall net benefit can be concluded for the current registration system, which gives right of title to medical practitioners, some features of which restrict competition (at least potentially). Without making a judgement about the strength of this net benefit, the review has concluded that it could be strengthened if certain changes were made to the act. Therefore, the status quo is not being recommended.

In regard to the overall intent and scope of the legislation, the following is recommended.

- Legislation to protect the public against unqualified practitioners using the title medical practitioner or variant specified in the act, or implying that they are qualified in those professions be retained. As in the present legislation, right of title should be restricted to those who are registered within a particular professional category and hold a current license to practise (section 56(1)(b)(c)).
- The present reference in the legislation which implies restricted right of practice (section 56(1)(a) be rescinded.
- The preclusion on the right to recover fees by unregistered practitioners (section 62(2)) be rescinded.
- The requirement that unregistered persons may not hold medical appointments (section 58) be rescinded.
- Provision be made for certain treatments or procedures which are assessed to have a high probability of causing serious damage if practised by persons with inappropriate qualifications and experience to be restricted to persons who can demonstrate they have appropriate qualifications and experience to practise them. Such restrictions should have the status of subordinate legislation, their introduction being subject to normal regulation impact assessment procedures.

Several recommendations are aimed at strengthening the public confidence in the intent of the act to protect public health.

- The objective of the legislation explicitly be to protect and inform the public, and should be clearly stated within the legislation.
- The legislation explicitly require all members of the boards unequivocally to serve the public interest, and for this reason no person should be appointed singly to represent the public interest.

For matters dealing with registration and licensing *per se*, no change is proposed regarding the structure of the current boards, which permits majority representation from the professions. However, some matters such as treatments or procedures which have a high probability of causing serious damage if practised by persons with inappropriate qualifications and experience, may need to be externally reviewed before they are proscribed by regulation.

In regard to the powers and discretions of the board, the following are recommended.

- Professional qualifications for registration be those that satisfy the board that the applicant has undertaken a course of studies and completed a period of supervised practise appropriate to medical practice. No reference to particular courses or professional associations should be made in the act.
- The requirement for residency in the Northern Territory for eligibility for registration (section 27 (2)(e)) be rescinded.
- The board be empowered to require the demonstration to its satisfaction of continuing competence as a condition of obtaining a licence to practise.
- The intent of personal fitness criteria be clarified in the legislation along the lines of demonstrating to the satisfaction of the board:
  - adequate physical and mental health;
  - absence of relevant convictions for indictable offences, statutory offences relating to the professional's practise, and findings of guilt in either civil or disciplinary proceedings in any jurisdiction; and
  - absence of relevant current criminal or disciplinary investigations in a jurisdiction outside of the Northern Territory.
- There be a mandatory requirement to inform the board of any changes in status in these regards (currently other medical practitioners are required to report impaired practitioners).
- The board be empowered to suspend or cancel registration on the basis of any such adverse information, subject to normal appeal procedures.

As regards the conduct of medical practitioners and medical companies, the case law basis for professional misconduct is considered to be sufficient to prevent false and misleading advertising. Restrictions on company structure appear not to have any protective impact on public health. Recommendations are that:

- the classification of certain advertising behaviour as grounds for professional misconduct be rescinded (section 38 (2)); and
- the restrictions on the structure of a medical company (section 54) be rescinded.

Appendix

A *Terms of reference*

THE REVIEW OF THE LEGISLATION shall be conducted in accordance with the principles for legislation review set out in the Competition Principles Agreement. The underlying principle for the review is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

Without limiting the scope of the review, the review is to:

- clarify the objectives of the legislation, clearly identifying the intent of the legislation in terms of the problems it is intended to address, its relevance to the economy and contemporary issues and whether or not the legislation remains an appropriate vehicle to achieve those objectives;
- identify the nature of the restrictions to competition for all relevant provisions of the specified legislation. This analysis should draw on the seven ways identified by the National Competition Council in which legislation could restrict competition, which include:
  - governs the entry or exit of firms or individuals into or out of markets,
  - controls prices or production levels,
  - restricts the quality, level or location of goods or services available,
  - restricts advertising and promotional activities,
  - restricts price or type of input used in the production process,
  - is likely to confer significant costs on business, or
  - provides some advantages to some firms over others by, for example, shielding some activities from the pressure of competition;
- analyse the likely effect of any restriction on competition and on the economy generally;
- assess and balance the costs and benefits of the restrictions for each anticompetitive provision identified;

- consider alternative means for achieving the same result and make recommendations including nonlegislative approaches; and
- clearly make recommendations. These should flow clearly from the analysis conducted in the review. If change is not recommended and restrictions to competition are to be retained, a strong net benefit for retention must be demonstrated.

When considering the matters referred to above, the review should, where relevant, consider:

- government legislation and policies relating to ecologically sustainable development;
- social welfare and equity considerations, including community service obligations;
- government legislation and policies relating to matters such as occupational health and safety, industrial relations and equity;
- interests of consumers generally or of a class of consumers;
- government legislation and policies relating to ecologically sustainable development;
- economic and regional development including employment and investment growth;
- the competitiveness of Australian business; and
- the efficient allocation of resources.

The review shall consider and take account of relevant legislation in other Australian jurisdictions and any recent reforms or reform proposals including those relating to competition policy in other jurisdictions.

The review shall consult with and take submissions from those organisations currently involved with the provision of health services, other interested territory and Commonwealth government organisations, other state and territory regulatory and competition review authorities, affected members of the medical profession and their organisations and members of the public.