COMPETITION POLICY REVIEW TEAM

DEPARTMENT OF HUMAN SERVICES

NATIONAL COMPETITION POLICY

LEGISLATION REVIEW

MEDICAL PRACTITIONERS ACT 1983

REPORT OF THE REVIEW PANEL

March 1999

The views expressed in the issues paper are the views of the Review Panel and do not represent the views of the South Australian Government. Any action taken in anticipation of the outcomes of the review process is at the risk of persons taking such action.

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EXECUTIVE SUMMARY

The Panel recommends that the purposes of the Act commence with the words, '*An Act to protect the public,'*and that *'high standards'* be replaced with *'appropriate standards'*

The Panel recommends that an appropriate penalty by for contravention of Section 31 (reservation of practice) be included in the Act

The Panel recommends that Section 31 (1) (b), recovery of fees or other charges be deleted

The Panel recommends no change to the requirements for registration and reinstatement in Sections 32 to 34

The Panel recommends that ownership restrictions on any person or business providing medical services and/or employing medical practitioners be removed

The Panel recommends that all registered practitioners employed by, or in any form of business partnership with unregistered persons, be required to inform the Board of the names of those persons, and that the Board should maintain a register of those persons' names.

The Panel recommends that a new clause be inserted in the appropriate part of the Act, making it an offence for any person to exert undue influence over a medical practitioner to provide a service in an unsafe or unprofessional manner.

The Panel recommends that the Act continue to empower the Board to restrict the use of inappropriate company names, which may be false, misleading or deceptive.

The Panel recommends that Section 69 ('Practitioners to be indemnified against loss') be proclaimed

The Panel recommends that membership of the Board be increased from eight (8) to eleven (11), including at least one additional person who is not a medical or a legal practitioner

The Panel recommends that the quorum for a Board hearing of a complaint should be three members rather than the current five, and that one of these must always be a person who is not a medical practitioner.

The Panel recommends that at least two additional members be appointed to the Medical Practitioners Professional Conduct Tribunal, and that all hearings be conducted with at least one member who is not a medical practitioner.

The Panel recommends that appeals from the Board or the Tribunal should be restricted to points of law, rather than the substance of the case.

The Panel recommends that evidence of repeated acts of unprofessional conduct be admissable at appeals

The Panel recommends that Sections 66, 67, and 68 be amended so that appeals resulting from decisions of the Board and/or Tribunal will be heard in the Administrative and Disciplinary Division of the District Court.

The panel recommends Section 21 , Board to keep proper accounts, be retained

The panel recommends Section 22, Annual Report by the Board be retained

The panel recommends Sections 37, 38 & 43 and Schedule 1(ownership of companies provisions) be removed form the Act.

The panel recommends Section 49 and regulation 9 (registered person to supply prescribed information) be retained.

The panel recommends Section 52 (medical practitionr to rep[ort unfitnes of registred persons) be retained.

The panel recommends Section 71 and regulation 11 (medical practitioers to submit details of intersts in Hospitals) be removed from the Act.

The panel recommends Section 72 (payment of compensation by a registered person to be reported to the Board) be retained.

INTRODUCTION

The following paper concerns the review of the *Medical Practitioners Act 1983*. The review is conducted in compliance with an obligation upon the South Australian Government under clause 5 of the Competition Principles Agreement. The Competition Principles Agreement is one of three agreements signed by the Commonwealth, State and Territory Governments in April 1995. These three agreements give effect to the National Competition Policy.

The obligation contained in clause 5 of the Competition Principles Agreement concerns the review, and where appropriate reform, of legislation which restricts competition. The guiding principle in undertaking this review is that the *Medical Practitioners Act* should not restrict competition unless:

(a) the benefits of the restriction to the community as a whole outweigh the costs;

and

(b) the objectives of the legislation can only be achieved by restricting competition.

The Terms of Reference for this review reflect the requirements of the Competition Principles Agreement. In addition, the Review Panel has considered whether administrative procedures required by the *Medical Practitioners Act* are unnecessary or impose an unwarranted burden on any person.

To satisfy the requirements of clause 5 of the Competition Principles Agreement the following documents have been reviewed:

Medical Practitioners Act 1983
Medical Practitioners Regulations 1983

This paper has been drafted by the Review Panel pursuant to the Terms of Reference, which are detailed in Appendix 1.

The paper is in four parts. The first part concerns the central issues of the review. The second part details the analysis of specific provisions of the Act and regulations. The third part examines the administrative burdens imposed by the requirements of the Act. Finally, Part 4 contains various appendices.

References to 'the Act' are references to the *Medical Practitioners Act 1983* and references to specific Sections are references to Sections of the *Medical Practitioners Act 1983* unless indicated otherwise. References to 'the regulations' are references to the *Medical Practitioners Regulations 1988* and references to specific regulations are references to regulations contained in the *Medical Practitioners Regulations 1983* unless otherwise indicated.

SUBMISSIONS

Before preparing this report, the Panel circulated an 'Issues Paper', identifying those aspects of the Act where matters of competition arise. Submissions and comments were invited from any interested persons and organisations, especially consumers, practitioners, employers and training providers, and written submissions received are listed in the appendices.

This report is being circulated to all those individuals and organisations who responded to the Issues Paper, to a number of other possibly interested parties, and on request. The Review Team will accept verbal or written submissions, by telephone, fax, postage or e-mail, and can also consult in person, by arrangement.

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The closing date for submissions is Monday, February 15th, 1999

PART 1: CENTRAL ISSUES

1.1 Purpose of Act

The objects Section of the Act states that the *Medical Practitioners Act* is an *'Act to provide for the registration of medical practitioners; to regulate the practice of medicine for the purpose of maintaining high standards of competence and conduct by medical practitioners in South Australia; to repeal the Medical Practitioners Act 1919-1976; and for other purposes.'* The Act establishes the Medical Board of South Australia, and The Medical Practitioners Professional Conduct Tribunal to achieve these objectives, and empowers them to enforce the provisions of the Act. The overriding purpose of the Act is to protect the public by ensuring medical care is of a safe standard, and is provided by persons who are identifiable within the community as possessing the necessary qualifications and/or experience to provide medical services. However this public protection purpose is not expressly stated in the Act. In addition the words 'high standards' suggest a role for the Board in excess of that required for the protection of the public. A word such as 'appropriate' more exactly defines the purpose of the legislation.

Discussion

In the Issues Paper, the Panel asked '*Should the Act state in its objectives that its purpose is to protect the public?'* Most submissions received touched on this point, with all but one[1] agreeing that an explicit statement to this effect was appropriate. To quote the Australian and New Zealand College of Anaesthetists, '--*the Act should definitely state in its objectives that its purposes include protection of the public. The College is principally concerned with provision of safe care of a high quality to the public.'*[2] Provided that the standards used to determine 'safe care of a high quality' are what would be reasonably expected by the public and the medical profession, then the exercise of the Act's provisions, such as those allowing the Tribunal to impose conditions, cancel or suspend registration, should not impose unjustifiable restrictions upon competition.

The Panel recommends that the purposes of the Act commence with the words, '*An Act to protect the public,'*[3]***,*** and that *'high standards'* be replaced with *'appropriate standards'*

1.2 Markets

The purpose of legislation review is to analyse the effect of legislative restrictions upon competition in markets. The identification of the relevant markets is imperative, therefore, for an accurate assessment of the impact of legislative restrictions upon competition. Competition within markets is competition in the broad sense of the ability to enter and participate in a market, not in the sense of individual rights to participate in a market. Competition policy, therefore, is not concerned with marginal behaviour, but concerned with broader competitive outcomes.

The potential impact of legislated restrictions upon an individual's participation in a market, therefore, is only relevant to legislation review where the impact on the individual is symptomatic of broader anti-competitive outcomes caused by the legislated restriction.

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[1] Australasian College of Dermatologists (SA) page 2
[2] Australian and anew Zealand College of Anaesthetists page 1
[3] Victorian legislation reflects this notion: Medical Practices Act 1994 (Under Competition Review)

This distinction is important in the context of reviewing legislation which empowers a body to take disciplinary action against individuals in a profession.

The ability to restrict or prevent an individual's participation in a profession is only relevant to legislation review if criteria for imposing such restrictions generally distorts competitive conduct in a market.

Medical Services

The provision of medical services is undertaken by medical practitioners some of whom are also registered specialists, through recognition of their additional training and experience. Medical specialists are regulated by the *Medical Practitioners Act* and are subject to the system of registration established by the Act. Medical practitioners may provide medical services which they believe is within their area of competence.

Medical practitioners may be employed by public or private health services, or be self-employed. There are approximately 5,200 registered medical practitioners (including specialists) in South Australia. The term 'medical practitioner' in this paper refers to both general and specialist medical practitioners.

In determining what is the relevant market, the ability to substitute the service should be considered. Such competition does not occur if a consumer requires medical treatment that only the medical practitioner may provide. There are specific services which general practitioners and specialists provide, some of which may be provided by both.

There is ongoing controversy about entry to the medical services market. While Australia overall has a very high number of doctors by international standards, there are major areas of unmet demand; particularly chronic shortages of general practitioners and specialists in rural areas. In this context, the Australian Competition and Consumer Commission has questioned entry standards for overseas trained doctors, and constraints on the number of practitioners accepted for specialist training by the Colleges.However, these are not adddressed in detail in this report, as they are generally not matters that could be greatly affected by any actions of the the Medical Board in South Australia..

There also constant shifts on the boundaries of medicine, through the increasing scope of practice of other registered persons (eg, nurses, podiatrists, optometrists) and unregistered persons, especially traditional and 'alternative' practitioners. The operation of the *Medical Practitioners Act* has less bearing on these matters than other Acts governing othe professions, largely because the Act does not set out to define the scope of medical practice beyond certain prescribed matters. The rapid expansion of the range of practices recognised for payment of medical benefits by the private health funds demonstrates increasing competition in a number of areas previously assumed to be the preserve of medicine.

Training Market

A requirement of registration is that the applicant has prescribed qualifications. One function of the Board is to make the necessary inquiries in relation to qualifications and thereby make recommendations to the Minister in relation to regulations prescribing qualifications and other requirements for registration (sub-Section 13 (2) (a) and Section 32). The market for providing medical training, therefore, may be affected by decisions of the Board, and, therefore, is also a market relevant to the review of the *Medical Practitioners Act.*

1.3 Restrictions

Restrictions upon competition are of three types:

(a) barriers to entering (or re-entering) markets;
(b) restrictions on competition within markets; and
(c) discrimination between market participants.

Each of the restrictions identified in the course of this review has been identified in terms of these theoretical types of restrictions. Such categorisation is useful for determining the impact of the restriction upon competition in the relevant market. For the purposes of this review restrictive provisions have been assessed as trivial, intermediate or serious. This assessment is provisional until the consultation process is complete.

There is no definitive means of identifying the correct weight to be ascribed to restrictions. The following, however, is the 'rule of thumb' utilised during the course of this review. A trivial restriction upon competition has only a minimal effect upon competition within a market.

There is no clear-cut delineation between intermediate and serious restrictions upon competition. Generally, however, an intermediate restriction upon competition is a restriction which imposes a substantial cost upon competition. In this context 'substantial' indicates other than a minimal effect upon competition. By comparison, a serious restriction is a restriction which prohibits entry or re-entry into a market, or prohibits certain conduct within a market.

1.4 Costs

Two categories of cost arise from the restrictions contained in the *Medical Practitioners Act*.

Firstly, the restrictions upon registration to the profession may cause the supply of medical practitioners to be less than the demand. In this context, restrictions upon conducting education and training may also contribute to a shortage of persons attaining sufficient qualifications to enable them to be registered.

Restricting numbers of medical practitioners may cause the unit-cost of medical services to rise. This may result in higher costs for consumers. (Whether restrictions on numbers causes
the overall cost to the community to rise is a matter of debate) Similarly, a short-fall in the numbers of medical practitioners will reduce the availability of medical services. The numbers of medical practitioners practising is the result of many factors which are discussed below.

The second category of cost is compliance costs.[4] These are the costs of registration and of complying with standards of competency and professional conduct. These impact upon competition if they are sufficient to dissuade participation in the market for medical services, or are substantial and passed on to consumers as an element of the price charged for medical services.

1.5 Public Benefits

[4] refer Appendix 2

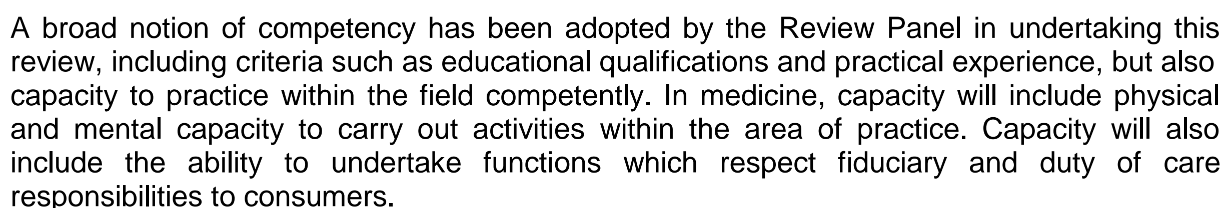
The professional regime established under the *Medical Practitioners Act* achieves significant public benefits. Restrictions upon entry to, and participation in the medical profession ensure that persons claiming to be registered possess the requisite qualifications and experience to fulfil those roles. All Australian states have regulated medicine for more than a century, with the earliest predecessor of the SA Medical Board being established in 1844.

The provision of professional services is often done in an environment of 'information asymmetry' between providers and consumers. The consumer will often lack the knowledge to assess the quality of the service being provided or the knowledge or expertise of the practitioner. They may be limited to judging a professional's ability to provide a service on the basis of their manner and presentation.

In such an environment, Government has a legitimate role in ensuring that professionals meet minimum standards of competency. The public can be confident that a person holding themselves out to possess certain qualifications and expertise does in fact hold this level of qualifications and expertise.

The provision of information to consumers is, therefore, a significant factor in promoting competition.
Deregulation of professions, without a concomitant increase in the knowledge of consumers, to enable them to make informed choices regarding service providers, will expose consumers to risks of harm without providing them with the means of avoiding this harm. Systems of registration provide a mechanism for providing a public record of the practitioner within a profession and any restrictions upon their ability to practise. The compilation of such information and its provision to consumers is a significant public benefit.

Restrictions upon conduct within a profession also preserve public confidence in the standards of professional care provided by members of the medical profession. A good example is the requirement that professionals only operate within their area of professional competence.



A broad notion of competency has been adopted by the Review Panel in undertaking this review, including criteria such as educational qualifications and practical experience, but also capacity to practice within the field competently. In medicine, capacity will include physical and mental capacity to carry out activities within the area of practice. Capacity will also include the ability to undertake functions which respect fiduciary and duty of care responsibilities to consumers.

PART 2: ANALYSIS OF RESTRICTIONS

Five categories of restriction have been identified in the course of reviewing the *Medical Practitioners Act*:

- 2.1 Title and Practice Protection;
- 2.2 Ownership and Business Restrictions;
- 2.3 Training Courses;
- 2.4 Disciplinary Actions;
- 2.5 Regulatory Bodies.

2.1 Title and Practice Protection

The Act contains restrictions which achieve title and practice protection. Restrictions upon competition concerned with practice protection restrict entry into a profession. By controlling registration, the Medical Board effectively determines who can practice medicine. Practice protection relates to qualifications and/or experience required to enter a profession, and professional standards and requirements of persons returning to, or seeking reinstatement in, the profession.

Practice protection may be achieved by the operation of the registration requirements together with the provisions which restrict unregistered persons from practising, and the reservation of title, or 'holding out', provisions.

Where these requirements are legislative requirements of registration in a profession, as in the *Medical Practitioners Act*, these requirements are a legislated restriction upon competition.

The concept of Government-regulated title protection obviously restricts use of a title by unregistered persons. This is usually justified by the need to inform consumers which practitioners have 'Government guaranteed' standards of training and accountability. The alternatives to such regulation are;

- self-regulation, where the profession may or may not organise to set its own standards and advertise these to the public;
- co-regulation, where the Government works together with accredited professional organisations to encourage all practitioners to meet standards for membership of those bodies;
- voluntary registration, where practitioners can choose to meet Government standards in return for the 'Government-approved' status that may deliver other benefits to their practice.

2.1.1 *Reservation of practice: Section 31*

Section 31 provides that only 'qualified' persons shall provide certain prescribed medical treatments under any circumstances, and any type of medical treatment for fee or reward. A 'qualified person' is a person (including a body corporate) who is registered or otherwise authorised by the *Medical Practitioners Act* or any other Act to provide medical treatment. Medical treatment is defined in Part 1 to include 'all medical or surgical advice, attendances, services, procedures and operations.'

This Section appears intended to restrict the practice of medicine for fee or reward to qualified persons. NSW legislation includes a similar restriction with the addition of a clause (111) that states "other health professionals not affected". [5]The reservation of practice is a barrier to entry into the market for medical services. It is a serious restriction on competition. However, the provision for other 'qualified' persons does open up a number of areas where it is not clear whether medical treatment is restricted to medical practitioners. Nurses, chiropractors, podiatrists, physiotherapists and other professionals have all at one time or another been authorised by their regulatory bodies to practise in fields previously held to be reserved to medical practitioners.

In addition, because this section does not specify any penalties for contravening the restriction, no offence is created. Therefore there is no way for the Board to enforce the provision. Given that this has been the situation for many years, it has to asked whether it is necessary to continue any attempt at such practice reservation.

There is public benefit in consumers having confidence that persons who provide certain treatment have the qualifications and expertise to provide that treatment. Medical Practice involves procedures which carry significant risks and which may be irreversible.

It is therefore appropriate to protect the public in some manner. Registration without effective practice reservation has prevailed until now. This review must consider alternative means to achieve public protection, such as protection under the common law, the *Fair Trading Act 1987 (South Australia)* and the *Trade Practices Act 1974 (Commonwealth)*.

Another approach may be to legislate to reserve the use of certain titles only, or to reserve the practice of only those procedures or treatments which carry significant risks. It is important that the method of public protection used be accessible and easily enforced to be effective.

The costs of reservation of practice to the public include the costs of registration as discussed in part 2.1.1, ie, the cost of becoming a 'qualified person'. This is justified if the system of registration is necessary to maintain public protection and confidence in the medical profession.

Discussion

The Panel asked '*Are there alternatives to the current system to protect the public from unqualified or incompetent persons undertaking medical treatment?*' All submissions addressed this question, and all supported the current arrangements.

The Panel believes that the alternatives to regulated restrictions are unsatisfactory, because of the exceptional degree of public trust put in medical practitioners to behave ethically and practise competently, often in private, with patients who may be lacking in information, and at high personal risk to their health.

[5] NSW legislation : Medical Practice Act 1992 Div 2 (for further Competition Review)

The Panel also asked, '*Is total reservation of practice for prescribed medical treatments justified?,* and; *'Is the prohibition (or at least intended prohibition) on provision of any medical treatment for fee or reward justified?'*

The Act as it currently operates creates a 'hybrid' reservation, in that treatment of certain conditions is expressly reserved to medical practitioners (Section 31 and Regulation 20), but there is no restriction on an unregistered person undertaking any other medical practice, provided it does not involve 'fee or reward'. However, as explained above, because there is no penalty and therefore no offence committed if a person acts to contravene Section 31, it is doubtful that any effective restriction is created.

The Panel received many comments about this matter. These were unanimous about the need for continuing restrictions for the prescribed conditions, and the Review Panel supports that view. The general constraint on making 'miracle cure' claims is a widely respected feature of the Australian health services, which protects members of the public from a variety of mis-information about serious illness. To that end, a penalty for offences against Section 31 (1)(a) (i) and (ii) is required. The Board can apply to prescribe other illnesses and/or treatments in Regulation 20 from time to time as new matters of public protection arise..

Some respondents (eg, the AMA[6]) believe that broader practice reservation should be implemented. This was apparently originally envisaged in the way the Act was framed, and would be achieved by stipulating a penalty for offences against the provisions of Section 31(1) (b), ie; by making it an offence to '*recover a fee or other charge for medical treatment'* It appears that doubts existed about the practical implementation of the restriction from the very beginning, as it has never been proclaimed.

As mentioned above, the problem with broader practice reservation of this type is that it could create a variety of restrictions on other registered and unregistered health practitioners; restrictions that do not appear to have been necessary to protect the public until now.

Given the above restrictions on treating prescribed conditions, and the many functions reserved exclusively for medical practitioners in other acts (eg, Controlled Substances Act, Firearms Act, Consent to Medical Treatment Act, and a number of acts which require medical assessments of individuals) the Panel believes that matters of practice reservation would be adequately dealt with if Section 31 (1) (b) was deleted. This would remedy a confusing situation, with no reduction of public benefit.

The Panel recommends that an appropriate penalty by for contravention of Section 31 be included in the Act

The Panel also recommends that Section 31 (1) (b) be deleted

[6] AMA(SA) submission page 3

2.1.2 Reservation of Title

Title reservation is achieved by Section 30, which prevents the holding out of a person as a medical practitioner or medical specialist unless that person is registered as such.

Any assessment of restrictions associated with reservation of title involves an assessment of the qualifications and/or experience required to utilise the title, and whether this level of expertise demands that the profession be recognised by the public through the use of a reserved title.

This review must also assess whether there is a need to legislate to ensure title reservation, or alternatively whether such title reservation can be achieved by the profession and laws regarding misrepresentation. The National Professional Engineers Register, and the register of Chartered Practising Accountants, are arguably both good examples of self-regulatory models that achieve the same purposes without any legal restrictions on their respective service provider markets.

Discussion

The Panel asked '*Is there a net public benefit in ensuring that the titles utilised by the various types of medical practitioners are reserved by means of legislation?*'The answer was uniformly in the affirmative, although one respondent suggested that the usefulness of the term 'doctor' was being eroded through increasing use by professionals such as Chiropractors.[7] The Panel does not believe there is an alternative to regulated title protection which can provide the public benefit of clearly identified practitioners who are accountable to a public statutory authority.

2.1.3 Registration requirements: Sections 32-34

The registration requirements of Sections 32 to 34 form part of the regime of practice protection. A person may apply to be registered as a medical practitioner, on the general and specialist registers. An applicant shall be registered under the *Medical Practitioners Act* where that person meets the criteria for registration. Pursuant to Sections 32 to 36 the relevant criteria are:

(a) has prescribed qualifications and experience;
(b) fulfils all other prescribed requirements; and
(c) is a fit and proper person to be registered on the specialist register or the general register

[7] Royal Australian College of Radiologists page 3

Qualifications and Experience

Criteria for registration based upon objective standards of competency, while being restrictions upon entering a profession, may be justifiable in terms of protecting the public where there is a risk of harm from persons who are not competent to provide certain services.

In relation to the services provided by medical practitioners, this degree of risk is significant. Medical practice is often an invasive service, in which the risk of cross-infection and other harms may be high. In addition many medical procedures are irreversible. Therefore persons holding themselves out as registered medical practitioners must be competent in the delivery of medical services. Attaining a qualification which in the opinion of the Board, is necessary to ensure competency is an objective criteria for attaining registration. The qualifications for all registered persons are set out in the regulations.

The Second Schedule to the regulations provides the prescribed qualifications of registration on the general register. These relate to the completion of listed courses or a certificate that the applicant has satisfactorily completed examinations conducted by the Australian Medical Council [8](and, previously, by the Australian Medical Examining Council). Part 2 of the Regulations also requires that the person produce evidence of satisfactorily completing a period of internship training.

The qualifications and experience required for registration on the specialist register are listed in the Fourth Schedule to the regulations.

The requirement for the completion of a course is a restriction on competition, the costs of which may be justified if the content of the course is necessary for the applicant to attain the competency required to practice in the relevant field of medical practice. Given the number of years of study required, especially for specialists, this is an intermediate to serious restriction on competition.

Similarly examinations such as those conducted by the AMC are an intermediate form of restriction on the entry of a person to the medical profession. The costs associated with the satisfactory completion of an examination may be justified if the examination is an effective demonstration of competency.

Restricting entry to medical practice may lead to anti-competitive costs if the demand exceeds the supply. However, while registration does affect the numbers of medical practitioners in the marketplace, there are other factors at work, such as University entrance requirements and provider numbers enabling practitioners to access Commonwealth medical subsidies.

The number of people who may attain the necessary qualifications is also limited by the numbers of places in the relevant courses. The numbers of places in a teaching institution is dependant upon funding to those institutions.

Other restrictions upon the numbers of medical practitioners include the availability of clinical practice placements (where required for the relevant course), and the cost of tuition.

Discussion

The Panel asked, '*Do the current educational requirements of registration unduly restrict access to the practice of medicine; ie; is the degree of restriction justified in terms of public benefit'*

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[8] Australian Medical Council Website : http//:www.amc.org.au/asses.asp

All submissions received commented positively on current standards required by the Board. While the Board is not obliged to accept any other bodies' accreditation of programs of training and clinical experience; ie; it has the power to prescribe these as it sees fit; in practice it chooses to work within national processes coordinated by the Australian Medical Council. Locally, the Board does accredit teaching hospitals for the purposes of post graduate training, via the Council for Early Post-Graduate Training (CEPSA). Such an approval means in effect that the hospital concerned , in the Board's view, can provide an appropriate internship for the number of post-graduate students nominated by the hospital.

Several stressed that the restrictions on numbers in courses, and on those subsequently receiving provider numbers, are not restrictions emanating from the Act. These are a function of University entrance requirements (in turn driven at least in part by Commonwealth funding of higher education) and Commonwealth health policy.

As discussed above, the training required is very extensive, expensive, and therefore a serious restriction on competition. However, in such a context of national (and in many cases international) uniformity in matters of pre-requisites for registration, the Panel recommends no change to the current approach of the Board.

Section 32 (b) '--all other prescribed requirements'

This clause may enable the regulations to specify attributes which do not relate directly to the competency of applicants. Requiring such attributes could create unjustifiable restrictions on competition. However the regulations do not currently prescribe any additional requirements for registration other than the person being 21 years of age, which is a trivial restriction in the circumstances, and no change is recommended.

'Fit and Proper Person'

The 'fit and proper person' standard may constitute an unjustifiable restriction upon competition depending upon how this standard is interpreted and applied by the Board and Committee. If the standard is purely competency based, this restriction may be justifiable.

Like other Registration Boards, the Medical Board is guided by a body of legal precedent, summarised in a Crown Law opinion obtained by the Psychological Board in 1985 which states that:

'The Board must consider matters affecting the moral standards, attitudes and qualities of the applicant, in so far as they relate to the applicant's proposed practice--.'

Current Board practice for determining whether the applicant is a fit and proper person to be registered is based on whether that person is competent to provide medical services in the relevant field of practice.
The Board has not refused an application for registration on this ground, but indicates that a criminal conviction for an offence such as fraud would be a likely ground to exclude a person based on the 'fit and proper person' requirement under the Act. If it did so, this would be a serious restriction, ie, prohibiting entry to the practice of medicine.

Although all registered persons must pay a fee annually to maintain their registration, there is no further evaluation of that person's fitness to practise unless they are the subject of a complaint. Some professions set minimum criteria for refresher training, or a maximum period out of practice after which the person must have their competence re-assessed. This is not the case for medicine in South Australia.

Discussion

The Panel asked *'Is the 'fit and proper' person requirement a necessary restriction on entry to the profession?'* and; '*If so, should it include objective standards such as having no criminal convictions for indictable offences?'*

All respondents agreed that 'fit and proper' is appropriate terminology to restrict entry to the profession. For example, the Royal Australian and New Zealand College of Psychiatrists observed that this had *'--historically been an accepted standard.'*[9] and the AMA notes that '-- *it is important that standards be established as to the type of person as well as the medical qualification'*[10] Some submissions stressed the need for the Board to retain flexibility about offences as a barrier to registration, saying, for example, '*--the Medical Board should have some leeway to ensure that a relatively minor offence does not become a permanent barrier to all forms of practice--'.*[11]

The Panel is satisfied that the current restriction is justified by the public benefit of a definition which has proved workable in restricting access of unsuitable persons to the practice of medicine.

The Panel also asked '*Should there be some periodic re-evaluation of each registrant's fitness to practise?'* This produced a mixed reaction, with most submissions from medical organisations stating that any such re-evaluation was their responsibility, and not that of any Government body. None of the South Australian acts regulating health professions address this notion directly, except for the current Nurses Act, which empowers the Board to require refresher training by persons who have not been registered for five years or more.

The Medical Practitioners Act gives the Board similar powers where a person has been removed from the register for any reason (Section 34 (4)) in that the Board shall reinstate a person if it is satisfied that;

'--*he has sufficient knowledge and experience of and is able to exercise the necessary degree of skill required for the practice of medicine;--'*

--which allows the Board to form a contrary view. However, if a person has been continuously registered, the Board has no choice but to reinstate unless some evidence has come to light that they are not a fit and proper person.

An amendment to Section 34 could allow for a 'pro-active' stance by the Board, but there would be considerable difficulties in arriving at an equitable and affordable system of periodic re-evaluation of all (or some sample of) registered persons. Therefore, rather than proposing additional restrictions in the Act, the Panel recommends continuing dialogue between the Board and the medical colleges about effective self-regulation of this issue.

Also included in Section 34 is the requirement that a person whose registration has been cancelled for unprofessional conduct may not apply for reinstatement for a period of two years. He or she must then satisfy the Board that they meet all the requirements for registration, including being a fit and proper person.

The requirement creates a serious restriction on the individual, but the broader anti-competitive costs are trivial because of the very small number of practitioners excluded. Most submissions referred to this provision, and all that did supported retention of the restriction, in the words of the SASMOA paper, because 'the period of two years --reinforces the seriousness of the cancellation of registration'.[12]

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[9] RANZCP submission, page 1
[10] Australian Medical Association (SA Branch) page 2
Royal Australasian College of Radiologists, page2[11]
[12] South Australian Salaried Medical Officers Association Page 2

The Panel recommends no change to the requirements for registration and reinstatement in Sections 32 to 34

2.1.4 Limited registration for the purposes of gaining experience or teaching, etc: Section 35

Section 35 enables limited registration where, in the opinion of the Board, the applicant for registration lacks the necessary qualifications or experience or other prescribed requirements, or fulfils these requirements but is not a fit and proper person, for unrestricted registration.

Under sub-Section 35(3), the Board may impose restrictions upon the places and times in which a registered person may practise medical practice, limit the branches of medical practice in which that person may practise, limit the period of registration, impose conditions of supervision or impose any other condition as the Board thinks fit.

The section allows for persons who do not meet all registration requirements to undertake additional training and experience which requires some provision of medical services. 35(1)(b) also allows for limited registration 'in the public interest' where a person not meeting registration requirements may be deemed competent to meet a specific need for medical services. This is consistent with requirements in NSW and Victoria.[13]

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[13] NSW Part 2 (7), Victoria Part 1 (8), (9)

This provision enables the Board to place a restriction upon a person's conduct within the medical profession. The costs of this restriction are reduced if the Board utilises criteria which accords with community and professional views on whether a person should be entitled to unrestricted registration. As long as the criteria used by the Board are based upon competence, the section may also have the effect of reducing the restrictive effect of registration requirements overall, in that it provides entry to the market of persons who would otherwise be excluded.

There is a benefit to the public in limitations being placed upon the registration of persons where the skills or expertise of the person are insufficient for them to qualify for unrestricted registration. The provision enables the Board to provide limited registration to a person who otherwise would not qualify for registration and, therefore, would be prevented from practising.

Provided that the criteria which the Board apply are based upon competency, and are applied consistently there are minimal anti-competitive costs of complying with this Section. While conditional registration is a restriction upon the individual professional, it is not an unjustifiable restriction upon competition in the market for medical services.

Discussion

This matter was not addressed by any submission. The view of the Panel is that the provision is useful, and generally acts to allow some practice where none would be possible otherwise. No change is recommended.

2.1.5 Specialist registration

Section 33 means in effect that a medical specialist can only hold out to be a medical specialist in the branch of specialist medical practice for which that person is registered. The branches of specialty are prescribed by the regulations (Third Schedule). This is a restriction upon conduct within the market. Victoria has positioned the registration of Specialists within the Act with a requirement for the Board to be satisfied and able to impose restrictions.[14]This is likely to be an intermediate restriction, depending upon how the Board gives its authorisation and whether the criteria are based upon competence. The public benefit in restricting holding out by a specialist is protection of the public, by ensuring the competence of a person claiming to be a specialist in a particular field.

Anti-competitive costs in the marketplace for consumers may be increased cost due to the need to obtain treatment from more than one source.

Discussion

The Panel asked, '*Are the restrictions on practice of medical specialties justified'* Most submissions commented on this restriction, and all those that did supported the current arrangements. There are ongoing debates about the role of the specialist colleges in restricting access to training, but any such problem is not necessarily a consequence of this Act.
The colleges are not mentioned in the Act, which gives the Board authority to register persons on the specialist register who have '*prescribed qualifications and experience'*.

However, the Regulations (Fourth Schedule) prescribe the specialist colleges responsible for managing training in each speciality, so the term 'prescribed' in the Act has been used by

[14] Victoria, Part 3 (11a)

Government(in most Australian jurisdictions) effectively to hand over regulation of these matters to the colleges.

This creates a restriction in the training market**,** in that no other organisations are able to provide specialist medical education which would lead to registration. There are benefits in continuing with the restriction, because of the practical difficulties in finding an alternative way of maintaining oversight of the breadth and depth of training required. There are currently fifty two specialities recognised in the third schedule of the Regulations, so it is difficult to envisage a system which does not place major reliance on the colleges for advice on training.

Universities might be an alternative, and could perhaps replace a college if an intractable difficulty arose in meeting public benefit objectives. However, given the Australasia-wide arrangements in medical specialities, it is unlikely that a single state board would seek to implement such a change.

It is sometimes suggested that the Colleges limit the places available for training in each speciality. The reality is much more complex. In relation to vocational training for General Practitioners for example, the Commonwealth Government has imposed a limit of 400 funded training places nationally. In most specialities the numbers coming into training are determined by the clinical supervisors and teachers available and the clinical experience opportunities in each state or territory. That experience is mainly limited by the number of positions available in the public sector in any given year, although in some specialities (eg, dermatology) private hospital -based training is increasingly common.

There is no evidence of any quotas imposed by the Colleges. However, individual acceptance decisions are usually made by state/territory branches of the Colleges, and a recent report (Brennan, 1998) emphasised the need for the Colleges to ensure that each branch had completely transparent selection processes for entry to training programs. This to be sure that arbitrary standards do not become an indirect method of limiting entry.

The other major advantage in delegating these matters to the colleges is reduced cost, in that colleges meet a considerable proportion of the costs of developing curricula, supervising students, and conducting assessments and examinations. Given that the colleges have no financial interest in the outcomes of the training process, this degree of self-regulation is effectively a working example of 'co-regulation' where the Government mandates a non-government agency to manage training and other matters regarding a professional group.

In the words of the AMA, '*These are matters for a different forum'*[15] No changes are recommended.

2.1.6 Fees: Section 54

A person cannot be registered or reinstated on a register until they have paid the prescribed fee(s). The current fee for general registration is $200, plus $100 for specialist registration, and the annual practice fee is $200.

A fee constitutes a restriction upon entry into the medical profession. It is likely to be a trivial restriction, unless it is unreasonably high and thereby dissuades entry or re-entry to the profession. The current annual practice fee for medical practitioners is higher than in several

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[15] AMA submission page 3

other states and territories (.a comparative table of fees is contained in Appendix 2.) but is unlikely to influence decisions on whether or not to practise medicine.
There is a public benefit in a system of registration of the medical profession, so the registration fee can be seen as a justifiable restriction on entry to the marketplace. The system of registration not only ensures the competence of persons entering the profession but provides a record of information available to the public and employers in relation to the registered person's qualifications, conditions on registration and any disciplinary action taken against that person.

The amount of fees fully covers the costs of the Board fulfilling its statutory roles under the Act, thereby providing another public benefit , ie, reduced cost of public administration. Because the Board receives no other funding, the amount of fees directly determines what functions it can carry out.

Discussion

The Panel asked, '*Does the fee for registration unduly restrict entry into the medical profession?'* The unanimous view put was that this is a trivial restriction, in line with fees applicable in other jurisdictions,[16] and essential to minimise the cost to the public. The consumer organisation Health Rights and Community Action went further, saying that '*The fee is nominal. We believe the fee could be increased, thus increasing the potential for the Board to exercise its functions more effectively'*

Certainly, the Panel recognises that the Board has a problem with resources, on the evidence of the backlog of complaints(see appendix 3) awaiting resolution. This is discussed in a later part of this report, and the suggested changes could increase the costs of administration. However, the Panel sees the actual setting of fees as a matter to be taken up by the Board if and when it sees the need. Therefore the Panel can only arrive at a view on the current fees, which it believes represent a trivial restriction on the market of provision of medical services, fully justified by the functioning of the Board at no cost to Government.

The Panel recommends no change to the level of fees, which can be varied from time to time by negotiation between the Board and the Government.

2.1.7 Variation, etc., of conditions imposed by the Board, Tribunal and Supreme Court: Sections 59 and 68

The Board, the Medical Professional Conduct Tribunal and the Supreme Court are empowered to vary or revoke a condition imposed by them respectively in relation to a person's registration.

The power to vary conditions may be utilised to impose conditions which restrict competition. Depending on the conditions imposed, this provision could restrict competition in a trivial through to intermediate manner. There is public benefit in enabling these bodies to vary and revoke conditions. The ability to revoke conditions may enhance competition.

The ability to vary conditions may also enhance competition if the body imposes less stringent conditions, which is generally likely since the bodies can only do so on the application of the registered person.

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[16] see table of fees in the appendices

Where the body imposes more stringent conditions this may also be justified if the conditions are in the public interest. The cost of this restriction is minimal, especially if the body introduces conditions which are reasonably required to protect the public interest, and the Panel recommends no change in this provision.

2.1.8 Suspension of registration of non-residents: Section 56

Section 56 enables the Board to suspend the registration of a person who has not resided in the Commonwealth for a period of twelve months and provides that such suspension shall remain in force until that person once again resides in the Commonwealth. This is a restriction on an individual's conduct within and re-entry to the medical profession, but not a restriction on competition within that market, since the person is absent. The purpose is to ensure that persons practicing in, or receiving an income from medical practices in South Australia are accountable to the Board and accessible by it, and maintain the competencies relevant to Australian medical practice. The Panel recommends no change to this provision.

2.1.9 Restriction of movement of medical practitioners between jurisdictions: Mutual Recognition

Systems of registration may inhibit movement of medical practitioners between jurisdictions, where medical practitioners registered in another jurisdiction are unable to register in South Australia. Registration regimes established under the *Medical Practitioners Act*, however, do not restrict movement of medical practitioners between jurisdictions due to the operation of the system of Mutual Recognition established under the *Mutual Recognition Act 1992 (Commonwealth)*.

Mutual Recognition enables medical practitioners in equivalent occupations interstate to be registered in South Australia. The object of the scheme is, essentially, that if a medical care provider satisfies the requirements for registration interstate that person will be registered in South Australia without further training. A person registered pursuant to this regime is subject to the same laws regarding practice as other medical practitioners registered in South Australia.

The Mutual Recognition Act (sub-Section 20(5)) does preserve the ability of the Medical Board to impose conditions upon practice provided these conditions do not arise from the fact that the applicant is registered pursuant to the Mutual Recognition Scheme.

2.2 Ownership and Business Restrictions

Sections 37--43 apply to bodies corporate. They provide for incorporated medical practices, practising medicine for fee or reward, be registered under the Act. These provisions restrict entry to the medical profession by prescribing requirements for the ownership of registered companies 'formed with the sole object of practising the profession of medicine'. Therefore they are a restriction upon competition. However an unregistered person or company can employ medical practitioners and is not subject to the same restrictions, so the restriction does not operate across the whole market for medical services.

2.2.1 Registration and ownership of Companies: Section 37

Section 37 provides for the registration of companies on the general register on certain conditions in relation to directors, members, voting rights etc. In particular, the ownership of registered medical practices is restricted to medical practitioners and their prescribed relatives. The Board must be satisfied that the memorandum and articles of association

comply with these conditions and are *'otherwise appropriate to a company formed for the purpose of practising the profession of medicine'.*

Sections 38 to 43 contain restrictions on the conduct of registered companies, including administrative requirements and restrictions on the number of registered persons a company may employ. this does not apply to NSW and Victoria. Section 39 prevents a registered company from practising in partnership with '*any other person'* unless authorised to do so by the Board. Western Australian legislation requires the body corporate to be registered with the Board and also to be liable as a registered person. [17]As medical practitioners move into new working partnerships in the field, often implementing individual care plans involving several professionals, the restriction on forming multi-disciplinary companies has become more serious. Section 40 restricts the number of medical practitioners that may be employed to twice the number of directors of the registered company.

These Sections constitute a barrier to entering the medical profession (as a director and shareholder) in the form of incorporated medical practices. They also potentially enable the Board to restrict competition depending on its interpretation of the term 'otherwise appropriate' in relation to articles of association

There may be public benefit in having appropriately qualified persons own and run a medical practice and in particular be responsible for the confidentiality, safety and public protection issues of a practice. If the Board or Tribunal are to discipline a company in relation to, for example, unprofessional conduct, it may be important for the Board and Tribunal to be able to discipline the directors also. If the directors are not registered persons their liability is not to the Board, but may be to subject to bodies of law such as the *Trade Practices Act*, corporations law and the common law.

There may also be a benefit to the public in reducing incentives for over-commercialisation of the medical profession. These Sections appear designed to discourage the establishment of large medical companies and 'chain-stores' which might be inclined to focus on profit-margins ahead of their duty to their patients.

The anti-competitive costs of this Section may include that the fees charged for medical services may be higher than in a situation where ownership is unrestricted, due to, for example, economies of scale.

Discussion

The Panel asked, *'Are the restrictions on ownership and conduct of registered medical practices justified?'* A number of South Australian Acts regulating professions have restrictions on ownership of practices. Some do not, but have provisions which are designed to give Board control of owners not registered in the relevant profession, including care of their premises and equipment, advertising and employment of appropriately qualified persons

The underlying concern that has lead to these restrictions is that unregistered persons in control of a business providing professional services may not be subject to an adequate level of accountability to protect the public interest.

This could lead to such problems as the following:

- attempts to influence registered persons to provide inadequate services which might put consumers at risk
- attempts to influence registered persons to over-service

[17] Western Australia legislation: Medical Act section 11 (40) (listed for Competition Review 1999)

- undermining of the registered person's accountability to the Board and/or consumers--eg, by claiming the responsibility is with the unregistered owner, who is not accountable to the Board
- inappropriate use of confidential consumer information

As described above, the current restrictions in South Australia are extensive, preventing most forms of access to unregistered persons from owning or part-owning a business practising medicine. Several submissions recognised this, and proposed some qualified loosening of the restrictions. The AMA suggests that;

' Company structures which allow registration with the Medical Board, have a majority of doctors as directors, and are subject to quality and ethical standards determined by the Medical Board, may be possible.'[18]

The Medical Board of SA takes the point further, saying;

'---lay ownership of medical practices and companies is a fact of life--the lay owners--should be required to meet the same professional and ethical requirements as registered persons'[19]*;*

and the College of Radiologists adds;

'It may be appropriate to relax ownership, but to ensure that owners, whether they are medical or non-medical, are registered by the Medical Board and have to guarantee quality of care and level of standards by the doctors in their employment.'[20]

The Panel sees this suggestion as going too far, in that it is clearly not possible or even desirable for the non-medical owner of a company to guarantee that any registered medical practitioner in their employ will practice safely and competently. The core purpose of this Act is and must remain the professional accountability of registered persons to the Board. However, there remains the need to counter the possibility of undue interference in the practice of medicine, and for legal accountability to be clear in the event of a complaint.

The Victorian Government has taken this route, relaxing ownership restrictions in most of its acts regulating the professions, but then including a general provision, which makes it an offence;

'--for an employer, registered person or company practitioner to exert undue influence over a health practitioner (medical practitioner in this case) to provide a service in a manner detrimental to the safety of the consumer'.

The objective is to ensure that unregistered proprietors are also accountable to the Board, where there is any confusion as to final responsibility. This concept is very recent and has not been 'field tested' for ease of interpretation and implementation, but the Panel believes that such a clause would go a long way towards protecting the public without the need for ownership restrictions.

It would need to be accompanied by a new requirement, ie, that all registered practitioners employed by, or in any form of business partnership with unregistered persons, must inform the Board of the names of those persons. Otherwise the task of identifying, maintaining a register of, and if necessary bringing to account non-medical owners would be beyond the resources of the Board. Once the Board has been informed of employer/ owners' identities, it could contact them to inform them of the new responsibilities created by the 'undue influence' clause.

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[18] AMA op cit. page 3
[19] Medical Board op cit page 4
[20] Royal Australasian College of Radiologists page 3

With these changes, all of Division 5 of the Act *('provisions relating to the practice of medicine by companies'*) with the exception of the new 'undue influence' clause, and a requirement to register with the Board, would be unnecessary and should be deleted. The concept of 'registered company practitioner' would be obsolete, and the articles of association, types of ownership, etc addressed in the current Act would no longer be of interest to the Board as matters of public protection. (although company names remains an issue--see the next section)

The Panel recommends that ownership restrictions on any person or business providing medical services and/or employing medical practitioners be removed

The Panel recommends that that all registered practitioners employed by, or in any form of business partnership with unregistered persons, be required to inform the Board of the names of those persons, and that the Board should maintain a register of those persons' names.

The Panel recommends that a new clause be inserted in the appropriate part of the Act, making it an offence for any person to exert undue influence over a medical practitioner to provide a service in an unsafe or unprofessional manner.

2.2.2 Regulation 14--Company Practitioner not to assume inappropriate names

Regulation 14, which is pursuant to Section 37, mentioned above, restricts the names of company practitioners, requiring that they be *'appropriate ----and not infringe any ethical standards of the medical profession'.* A restriction on a company's ability to market itself is a restriction on conduct within the market. The severity of the restriction in this case will depend greatly on the Board's interpretation of the words 'appropriate' and 'ethical'.

There is public benefit in prohibiting misleading or deceptive names. The benefit of this regulation is minimised by consumer protection under the general law such as the *Trade Practices Act*, but it may beneficial to the public to have a more accessible enforcement body such as the Board.

Queensland Health have a published a 'preferred option' relating to the ownership and naming of companies that includes the notification of a company name to the Board.[21]

The cost on a company's ability to market itself will be minimal if clients are attracted to a medical care provider based on criteria such as expertise or professional reputation. However there is a tendency for consumers to take into account other criteria, due to the 'information asymmetry' discussed in part 1.5.

Unrestricted naming could lead to greater competition to attract patients, which might in turn lead to increased business for lower priced or otherwise more attractive services. The restriction clearly inhibits use of an important marketing strategy, which may be leading to less competitive outcomes overall.

Discussion

The Panel asked '*Is the restriction on company names justified?'* As discussed in the preceding section, the Panel recommends deleting references to 'company practitioners' as a concept. However, the use of company names is an important issue with medical services. Names which suggest false and/or misleading claims to cure medical conditions are an unfortunate fact of life in many countries, often leading to increased information asymmetry

[21] QLD Health Draft Policy paper 1996 pg 50

for consumers lacking expert knowledge. All submissions support this type of restriction, including two consumer organisations [22]

The AMA in its submission, puts the position thus;

'The definition of 'inappropriate' is fluid and recognises the changes in the commercial environment over time, but still retains a measure of control (over) marketing which may detract from the acceptance and trust of the profession..'[23]

Other regulated professional groups in South Australia are currently much less constrained in advertising than medicine, including in their choice of company names. Prohibiting such examples as 'the Cancer Cure Company' [24] is clearly in the public interest, but the very limited forms of company name which are the current norm suggest a much broader definition of 'inappropriate'. is being applied.

Professional associations, including the colleges of specialist medicine, and the AMA, are free to require whatever standards they wish of their members. The role of Government is limited to public protection, which should be the only test used to determine what is 'inappropriate'. The Panel recommends that a clause such as that at Regulation 15(a) (*'--the name shall be appropriate--'*) be retained, as there may be a need for the Board to intervene from time to time in the public interest.

The Panel wishes to emphasise that this power is not designed to be used as an arbiter of good taste, or to ensure a particular public image for the profession.

The Panel recommends that the Act continue to empower the Board to restrict the use of inappropriate company names, which may be false, misleading or deceptive.

2.2.3 Practitioners to be Indemnified Against Loss

Section 69 has not been proclaimed but may still be relevant to this review. This Section prohibits a medical practitioner or clinical medical technician from practising as such unless he or she is insured in a manner and to an extent approved by the Board against civil liabilities that might be incurred by that person in the course of his or her practice.

This restricts a persons ability to practise medical practice and acts a barrier to entry to the medical profession. If proclaimed, it would be an intermediate restriction upon competition.

There is public benefit in ensuring registered persons are adequately insured to cover any liabilities incurred by them against a member of the public.

Anti-competitive costs would only arise from this Section if the cost of the insurance deterred potential registered persons from practising and thereby significantly reduce the number of medical practitioners or clinical medical technicians entering the medical profession. In relation to medical practitioners, most are insured by choice with medical defence organisations, at costs ranging up to tens of thousands of dollars per annum

Discussion

The Panel asked '*Should Section 69 be proclaimed; ie; should professional indemnity insurance be mandatory for registered persons, or would this create costs such as to significantly reduce the number of registered medical practitioners?'*

[22] Council on the Ageing, page 2 and Health Rights and Community Action page 5
[23] AMA op cit page4
[24] Medical Board op cit page 4

In practice, virtually all medical practitioners are insured by choice. There was no evidence provided in the submissions to indicate that making this a requirement would deter a person from entering the market. The QLD Draft Policy Paper reflects an earlier Commonwealth position in the Govt 'Review of Professional Indemnity Arrangements for Health Care Professionals' of November 1995.[25]

All submissions which addressed this issue agreed that indemnity insurance is an important issue. Given that the primary function of the restrictions overall is to protect the public, it follows that protection of this most basic kind should be guaranteed. The Review Panel concludes that the practical effect of proclaiming this restriction would be trivial and is justified in the public interest.

The Panel recommends that Section 69 ('Practitioners to be indemnified against loss') be proclaimed

2.4 Disciplinary Actions

The Board and the Tribunal are empowered by the Act to discipline registered persons guilty of 'unprofessional conduct'. A complaint against a medical care provider is dealt with by the Board, unless the Board believes the allegations are 'sufficiently serious', in which case the matter is referred to the Tribunal.

Upon the Board finding a person guilty of unprofessional conduct it may reprimand the person (Section 54 (5)). The Tribunal may reprimand or fine (not exceeding $5000) a person found guilty of unprofessional conduct or may suspend, cancel or impose conditions in relation to that person's registration (Section 58(3)).

The Tribunal's powers to discipline are potentially restrictions upon the conduct of registered persons. Central to these restrictions is the definition of 'unprofessional conduct' and its application by the Board and the Tribunal. Section 4 provides that 'unprofessional conduct' includes improper or unethical conduct, incompetence or negligence, contravention of a provision of the Act, or of an order pursuant to the Act.

This definition of 'unprofessional conduct' may be restrictive depending upon the manner in which the Board or the Tribunal interprets the phrases 'improper or unethical conduct' and 'incompetence or negligence'. Determinations by the Board or Tribunal that certain conduct is 'unprofessional' constrains behaviour within the medical profession. Depending upon the approach of the Board and the Tribunal this may be an intermediate or serious restriction upon competition.

There is an obvious public benefit in including 'improper and unethical conduct' and 'incompetence and negligence' within a definition of unprofessional conduct. Public safety and confidence in the medical profession should be maintained, and these broad definitions give the Board and Tribunal greater flexibility in dealing with complaints than would be available in most courts of law.

Restrictions upon conduct, and hence upon competition, arising from the disciplinary structure of the Act only give rise important anti-competitive costs if inappropriate standards in relation to 'unprofessional conduct' are applied. Provided that the standards used to determine unprofessional conduct are what would be reasonably expected by the public and the medical profession, then the exercise of the Tribunal's powers to impose conditions, cancel or suspend registration should not impose unjustifiable restrictions upon competition.

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[25] Qld ib id p 68

However, it is also arguable that the standard of conduct applied should be more widely used public standards for corporate and individual liability, which may lead to a lower standard of service (while still requiring competence) , which in turn may lead to lower costs.

Discussion

The Panel asked, '*Does the definition of 'unprofessional conduct' adequately reflect community and professional expectations of conduct?*, and,

'Should a 'lower' standard of conduct be applied to reflect the standard required by the public?'

All submissions touched on these questions, and there was unanimous support for maintaining current standards. The Board has issued a booklet, *'Professional conduct and discipline: Fitness to practise'* (June 1998), which is not provided for in the Act and is not enforceable in itself. However, in any disciplinary proceedings the Board and the Tribunal are guided by the booklet in determining whether a registered person's conduct has been 'unprofessional'.

The guidelines cover a registered person's responsibility to patients, to colleagues and to the profession. It is important in the context of public protection, in that it makes the Board's interpretation of 'unprofessional conduct' more transparent to both the public and profession. This is particularly important in the environment of information asymmetry and where each profession may have a different standard of conduct. It is important, therefore, for the booklet to be readily available to the public and the profession.

Although there may be a potential for the Board and the Tribunal to restrict conduct, in practice any restrictions have been on a small number of individual person's conduct or right to practise and thus not on competition in the market as whole.

The Panel recommends no change to the definitions used by the Board, as set out in the Guidelines.

2.5 Regulatory Bodies

The Act establishes two bodies to regulate the medical profession:

(a) The Medical Board (Section 6);

(b) The Medical Professional Conduct Tribunal (Section 23)

These bodies together are responsible for the registration of medical practitioners, enforcement of the Act and discipline under the Act. As enforcement and disciplinary bodies, it is possible for them to create, and impose, restrictions upon competition in the medical profession. It is also possible for the Board to restrict competition within the market for medical training/education.

The membership and proceedings of these bodies, legislative restraints upon the use of powers, including appeals processes, and the functions of the bodies are relevant, therefore, to the extent to which they could restrict competition through the exercise of their functions.

2.5.1 The Medical Board

Functions of the Board: Section 12

Section 12 lists the functions of the Board. These functions include:

(a) to consult with appropriate authorities as to syllabuses and courses to enable persons wishing to apply for registration under this Act to acquire the necessary qualifications, experience and skill;
(b) to make recommendations to the Governor in relation to regulations prescribing the qualifications, experience and other requirements to be fulfilled by persons applying for registration under this Act;
(c) to make recommendations to the Governor in relation to the making of other regulations under this Act;
(d) to establish and maintain registers of persons qualified to practise medicine in accordance with this Act;
(e) to carry out such other functions as are prescribed by this Act.

These functions have the potential to enable the Board to restrict entry into and participation within the medical profession. Sub-Sections 13 (a) and (b) may enable the Board to restrict the market of providing training for the medical profession. Sub-Section 13 (e) may enable the Board to restrict entry into the profession by enabling the Board to set the standard for registration (see discussion on Section 30).

However the scope for the Board to use its powers to restrict competition is minimised by sub-Section 13 (1), which directs that the Board should exercise its functions ‘with a view to achieving and maintaining the highest professional standards both of competence and conduct in the practice of medicine’.

In addition the Act provides safeguards by way of provisions relating to the procedures of the Board, the appeals procedure set out in Part 5 of the Act and natural justice provisions. Relevant also to this review is the membership of the Board, as this may determine how the Board exercises its power.

The Panel recommends no changes to the stated functions of the Board.

Membership of the Board and Tribunals: Section 7 and 23

Section 7 provides that the Board includes five persons nominated by the Minister, of whom three must be medical practitioners, one a legal practitioner and one who is neither a legal practitioner or a medical practitioner. The AMA, University of Adelaide and Flinders University also have one position each, making a total of eight Board members.

This Section may tend to restrict competition in that it discriminates between competitors by not allowing for membership of persons, other than registered medical practitioners, who may be entitled to practice in closely related areas. It may therefore tend to produce a pattern of decisions which restrict competition from these groups.

The section may indirectly create restrictions in the market for medical training. The higher education market has been extensively de-regulated in recent years, with more competition between universities, between universities and TAFE, and between public and private providers. Guaranteed representation for existing providers only may reduce the likelihood of different products and providers being given proper consideration.

The membership might also not adequately reflect the views of employers of medical practitioners, which may lead to restrictions on their capacity to provide medical services in a cost-efficient manner.

The Section is likely to be a trivial restriction on competition, as long as the operations and decisions of the Board are transparent.

There may be a public benefit in the majority of members of the Board having a specific knowledge of the profession. There may also be a higher rate of compliance with the policies of the Board from within the ranks of registered medical practitioners because of its composition

Discussion

The Panel asked '*Is the composition of the Medical Board appropriate in view of its functions?'* and,

'What should the balance between non-registered persons and registered persons on the Board be?' and,

'Is the membership of the Tribunal appropriate for the functions it undertakes?'

Submissions generally echoed the views of the College of Physicians, viz;

'The current Board and Tribunal structures and functions seem eminently workable fair and proven.' [26]

Two possible improvements were canvassed; improved consumer representation and proposals to make it easier to convene Tribunals. On the matter of consumers, two

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[26] op cit page 1

submissions argued that there should be a more explicit requirement for at least one member of the Board to represent consumer interests. The Panel believes that the current requirement for a member who is '*nether a medical practitioner nor a legal practitioner'* is adequate to the purpose. Protecting consumer interests (*'An act to protect the public---')* is the primary responsibility of all members of the Board and Tribunal, and the capacity to serve effectively in that task should guide all appointments.

A major problem of the current structure is the requirement for Board hearings of complaint matters to have a quorum (5) of Board members present, and the Tribunal to have a maximum of five members of whom at least three must attend any hearing of a matter. Given that there are only eight (8) members of the Board in total at present, the result has been extreme difficulties in arranging Board and Tribunal hearings, resulting in a worsening back-log of unheard matters[27] The Panel believes that more Tribunal members on the one hand, and a smaller quorum for Board hearings on the other, would ease this situation.

The Panel recommends that membership of the Board be increased from eight (8) to eleven (11), including at least one additional person who is not a medical or a legal practitioner

The Panel recommends that the quorum for a Board hearing of a complaint should be three members rather than the current five, and that one of these must always be a person who is not a medical practitioner.

The Panel recommends that at least two additional members be appointed to the Medical Practitioners Professional Conduct Tribunal, and that all hearings be conducted with at least one member who is not a medical practitioner.

2.5.2 Incompetence and Incapacity: Sections 50 & 51

Part of the Board's function under the Act is to deal with complaints in relation to the incompetence or incapacity of a registered person.

Section 50 empowers the Board to make inquiries into allegations that a registered person has practised in a branch of medical practice without having or exercising sufficient knowledge, experience or skill. If the Board is satisfied that the allegations are established, it may impose conditions on the person's right to practise.

Section 51 empowers the Board to suspend a persons registration and impose conditions on a person's right to practise medical practice if the Board is satisfied that the ability of a registered person is impaired to such an extent that it is desirable, in the public interest, that such an order be made.

The ability to suspend registration and impose conditions is a restriction on a person's ability to practise medicine. This is a trivial to intermediate restriction, depending on how the Board interprets the Section and the stringency of conditions it imposes.

There is public benefit in a body being able to suspend and impose conditions upon persons who are not competent to practise medical practice or whose ability to practise medical practice is impaired. If the Board uses objective standards of competency and capacity, the anti-competitive cost is minimal. The legislative safeguards discussed below (at 2.5.4) also help to minimise any anti-competitive costs.

[27] see appendices for the 1997-8 situation

2.5.3 Appeals mechanism

Section 66 of the Act enables appeals to the Supreme Court against decisions of the Board and the Tribunal concerning registration, the imposition of conditions of practice, reprimands and order . The powers of the Supreme Court in relation to an appeal from a decision of the Board or the Tribunal are set out in Section 66 (3). These powers are to affirm, vary or quash the decision, reprimand or order, remit the matter back to the Board or the Tribunal for further hearing or consideration or for rehearsing; and make any order as to costs.

The Panel believes these provisions are a useful safeguard against the Board and the Tribunal from exercising their powers in an anti-competitive manner. However, it has become apparent with with this and a number of similar arrangements (such as for the Dental Board, and the Physiotherapy Board) that appeals to the Supreme Court tend to be more expensive for all parties, and involve longer delays, than can be obtained by appeals to the Administrative and Disciplinary Division of the District Court.

It is also apparent that delays are caused in part by the lack of a restriction on the matters which may be considered by an appeals court. The Panel believes that the right of appeal should be restricted to points of law, ie, alleged failures of proper process, rather than the substance of the alleged unprofessional conduct.

Another matter which has arisen in regard to appeals is the restrictions on evidence which is accepted by the Supreme Court. The particular problem is the requirement to present complaints about individual alleged instances of unprofessional individually --ie, one alleged incident per hearing. Public protection, which is the paramount concern of the Board, is often served by recognising a pattern of complaints or reported incidents which mean that informal methods of correcting the problem are not sufficient. It is precisely these sequences of events which cannot be tendered at an appeal as the logic for the Board's decisions.

The Panel recommends that appeals from the Board or the Tribunal should be restricted to points of law, rather than the substance of the case.

The Panel recommends that Sections 66, 67, and 68 be amended so that appeals resulting from decisions of the Board and/or Tribunal will be heard in the Administrative and Disciplinary Division of the District Court.

The Panel recommends that evidence of repeated acts of unprofessional conduct be admissable at appeals

PART 3: ADMINISTRATIVE REQUIREMENTS

The Review Panel is required during the course of this review to examine the provisions of the Act which impose administrative obligations upon persons and determine whether these obligations are unnecessary or impose an unwarranted burden.

The Panel asked : *Do any of the above administrative requirements impose an unwarranted or unnecessary burden upon any person?*

Section 21 The Board must keep proper accounts of its financial affairs and these shall be audited at least once a year.

It is in the interest of the public to have the Medical Board held accountable for financial management of all funds. The government through the instrument of the Auditor-general has a responsibility to the public to validate the process of the use of funds.

The panel recommends: Section 21 be retained

Section 22 The Board must prepare and deliver to the Minister, on or before 30 September, an annual report detailing the administration of the Act and containing the audited accounts.

It is in the interest of the public to have the Medical Board held accountable for all actions including finance as mentioned above. Other functions are required to be scrutinised to ensure the Board is meeting its responsibilities to the public under the Act in a transparent manner ie registration of medical practitioners, managing of complaints, and other functions prescribed by the Act.

The panel recommends: Section 22 be retained

Section 37 The requirement to obtain the Board's approval of a company's memorandum and articles of association.

Section 38 Companies must lodge an annual return containing specified information with the Board. The required form is contained in the First Schedule to the regulations.

Section 43 The requirement to obtain the Board's approval to alter a company's memorandum or articles of association.

These three sections and the schedule referred to are a restriction as there is no reasonable cause for the collection or approval of this information which adds an administrative burden in the management of a small business. The collection of data as to the current ownership of a practice is relevant, and may be sought when and if necessary, but not the normal function of business practices.

The panel recommends: Sections 37, 38 & 43 and Schedule 1 be removed form the Act.

Section 49 The Board may require a registered person to supply it with prescribed information in relation to that person's employment and medical practice. This information is prescribed in regulation 9.

The requirement for a registered person to inform the Board of employment and practice is a restriction and administrative burden for a practitioner who may be acting as a locum or otherwise without permanent employment. The public interest may be served, however, by the Board's ability to locate the current place of employment of a registered practitioner against whom a complaint is made, or for similar purposes where their residential address is not sufficient.

The panel recommends: Section 49 and regulation 9 be retained.

Section 52 Medical practitioners are required to report unfitness of a registered person. The information to be included in such report is contained in regulation 10.

The requirement for a medical practitioner to report unfitness of a registered person appears in professional registration legislation related to the practice of registered health professionals. It is necessary for the public to be able to be confident in the fitness of a practitioner registered by the Board, a change to that status is information necessary for the protection of the public, and may be viewed as a community service obligation of the Board.

The panel recommends: Section 52 be retained.

Section 71 Medical practitioners and prescribed relatives are required to submit details of their interest in hospitals. The information to be included is set out in regulation 11.

This section and the regulation referred to are restrictions as there is no reasonable cause for the collection of this information which adds an administrative burden in the management of a business. The collection of data as to the current ownership or interest in a hospital is not relevant to the practice of a registered practitioner, unless there is action pending about the function of that hospital, at which time all interests can be searched.

The panel recommends: Section 71 and regulation 11 be removed from the Act.

Section 72 Where a registered person has been ordered to pay compensation or has agreed to pay a sum of money in relation to a negligence claim, that person must provide the Board with information in relation to the claim. The information is prescribed in regulation 12.

Public protection is offered by the completion of the cycle of complaint, civil or criminal hearing, judgement or compensation and professional sanction. This is necessary to ensure that circumstances leading to such actions are adequately addressed from the position of the professional conduct of the practitioner.

The panel recommends: Section 72 be retained.

PART 4: APPENDICES

APPENDIX 1

LEGISLATION REVIEW
MEDICAL PRACTITIONERS ACT 1983
TERMS OF REFERENCE

SUMMARY

Under the Competition Principles Agreement ('the Agreement') the Government of South Australia is required to include in proposals for new legislation that contain restrictions upon competition evidence that:

(a) the benefits of any restriction to the community outweigh the costs

(b) the objectives of the legislation can only be achieved by restricting competition

The Medical Practitioners Act 1983 will be examined during the legislative review in accordance with the obligations contained in Clause 5 of the Agreement. Regulations enacted under the Medical Practitioners Act will be examined concurrently.

REVIEW PANEL

George Beltchev - Executive Director, Corporate Development
Dr. Michael Jelly - Chief Medical Officer, Department of Human Services

David Wilde - Registrar, Medical Board of SA
David Meldrum - Director, Competition Policy Review Team

OBJECTIVES OF THE REVIEW

When considering the appropriate form of regulation the Review Panel will attempt to achieve the following objectives:

1. Regulation should only be retained where the benefits to the community as a whole outweigh the costs: and if the objectives of the regulation cannot be achieved more efficiently through other means, including non-legislative approaches.
2. Pursuant to Clause 1 (3) of the Agreement, in assessing the benefits of the regulation regard shall be had, where relevant, to:

   - effects on the environment
   - social welfare and equity
   - occupational health and safety
   - economic & regional development
   - consumer interests, the competitiveness of business including small business
   - efficient resource allocation
3. Compliance costs and the administrative burden on small business should be reduced where feasible.

ISSUES TO BE ADDRESSED

1. Clarify the objectives of the Medical Practitioners Act 1983, including the identification of the public benefit of the Act, and provide assessment of the importance of these objectives to the community.

2. Identify restrictions to competition contained in the Act, regulations made under the Act, Codes of Practice and other documents.

   2.1 describe the theoretical nature of each restriction (eg: barrier to entry, restriction to competitive conduct within the market, discrimination between market participants)

   2.2 identify the markets upon which each restriction impacts

   2.3 provide initial categorisation of each restriction (ie: trivial, intermediate or serious)

3. Analyse and describe the likely effects of these restrictions on competition in the relevant markets and on the economy generally:

   3.1 what are the practical effects of each restriction on the market ?

   3.2 assign a weighting to the effect of each restriction in the market

   3.3 assess what is the relative importance of each restriction in a particular market to the economy as a whole

4. Assess and balance the costs and the benefits of the restriction.

5. Where the restriction is justifiable on the basis of public benefit, consider whether there are practical alternative means for achieving the objectives of the medical Practitioners Act 1983 including non-legislative approaches.

6. Consider whether any licensing, reporting or other administrative procedures are unnecessary or impose a burden on any person.

CONSULTATION

The Review Panel will review submissions received in the consultation process undertaken within the prescribed period. An Initial Consultation List will be provided for comment as soon as possible and expanded as necessary.

REPORT

The Report to the minister will contain:

Terms of Reference of the review
Persons and groups consulted
Analysis and recommendations

APPENDIX 2

COMPARISON OF REGISTRATION FEES - MEDICAL PRACTITIONERS

Jurisdiction	Annual practice fee
Australian Capital Territory	**$140**
New South Wales	**$140**
Victoria	**$200**
Tasmania	**$200**
Queensland	**$160**
South Australia	**$200**
Northern Territory	**$150**
Western Australia	**$180**

APPENDIX 3

CONSULTATION LIST

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Ms Roxanne Ramsey
Executive Director
Country
DHS

Mr Brian Dixon
Executive Director
Aboriginal Health
DHS

APPENDIX 4

DOCUMENTS CONSULTED

⇒ Medical Board of South Australia 14th Annual Report, period ending 30 June 1997

⇒ Medical Board of South Australia - Guidelines for the Advertising of Medical Services

⇒ 'Australian Medical Colleges and Competition Policy' : Peter Phelan at
http://domino.ama.com.au/DIR0103.......

⇒ Review of Nurses Act 1993, and Medical Practice Act 1994 Discussion Paper.
Victorian Department of Human Services October 1998

⇒ Australian Medical Council - Assessment of overseas Medical Qualifications
http://www.amc.org.au/assess.asp

⇒ Medical Practices Act 1992 (NSW)

⇒ NSW Health Department Issues Paper, Medical Practices Act 1992 (September 1998)

⇒ Medical Act 1939 (QLD)

⇒ QLD Health Review of Medical & Health Practitioner Registration Acts, Draft Policy Paper (September 1996)

⇒ Mutual Recognition Act 1992

⇒ National Competition Council 'Considering the Public Interest under the National Competition Policy (November 1996)

SUBMISSIONS

Australian Medical Association (SA Branch)

Australian College of Dermatologists, SA Faculty

Royal Australian College of Radiologists

Australian & New Zealand College of Anaesthetists, SA Regional Committee

Health Rights and Community Action

Medical Board of SA

The Royal Australian and New Zealand College of Psychiatrists (SA Branch)

Council on the Ageing

The Royal Australian College of Physicians (SA State Committee)

South Australian Salaried Medical Officers Association