MEDICAL PRACTICE ACT 1994

VICTORIA

NATIONAL COMPETITION POLICY REVIEW

FINAL REPORT

March 2001

Contents

Executive Summary

The *Medical Practice Act* was passed by the Victorian Parliament in 1994. The Act establishes the Medical Practitioners Board of Victoria and provides for the registration of medical practitioners and regulation of their standards of practice. As of 1st September 1998 there were approximately 14,500 medical practitioners with general registration in Victoria.

A Departmental review of health practitioner regulation completed in 1990 recommended a consistent approach to registration across all health occupations. Since it was enacted in 1994, the *Medical Practice Act* has provided a model for review of all other health practitioner registration Acts.

The review of the *Medical Practice Act* has been undertaken in accordance with the *Guidelines for Review of Legislative Restrictions on Competition* as required under the National Competition Policy and as part of the Department of Human Services' rolling program of review of health practitioner regulation. Terms of Reference for the review were approved in March 1998.

The NCP panel identified a number of existing legislative provisions in the *Medical Practice Act* that might impede competition. These were of two types, professional registration provisions in the form of restriction on the use of professional titles, and restrictions on advertising by registered practitioners. A public discussion paper was released in October 1998, following a series of consultation meetings with key stakeholders. Over 160 submissions were received during November and December 1998. Following the election of the Labor Government in September 1999, a further round of consultations was held with key stakeholders, including the AMA (Victorian Branch) and the Medical Practitioners Board of Victoria.

This report contains the findings and recommendations of the National Competition Policy Panel convened to conduct the review. In response to the NCP panel's recommendations in March 1999, the Government introduced into the Victorian Parliament the Health Practitioner Acts Amendment Bill 2000. The Act was passed in May 2000. The purpose of the Act was to amend the *Medical Practice Act 1994* to update its provisions and implement the recommendations of the NCP Panel.

A number of restrictions on competition have been retained or introduced in the amended *Medical Practice Act 1994* following passage of the *Health Practitioner Acts Amendment Act 2000*. These are:

- Power for the Board to register those medical practitioners who have the required qualifications as specified by the Board.
- Restriction on persons who are not registered from using the title 'registered medical practitioner' or any other title calculated to induce a belief that they are registered.
- Limited advertising restrictions on registered medical practitioners.
- Powers for the Board to require registrants to provide evidence of satisfactory arrangements for professional indemnity insurance as a condition of registration.

The NCP Panel recommended that protection of title continue to be the main form of legislative restriction in the *Medical Practice Act*. No legislative restrictions on the practice

of medicine were recommended. The Panel recommended retention of provisions that prevent persons being registered under the Act as medical practitioners unless they have achieved the qualifications recognised by the Medical Practitioners Board of Victoria and have provided the information required by the Board for registration. Unregistered persons are unable to:

- assume the title 'Registered Medical Practitioner'; or
- hold themselves out as qualified and registered, including adopt any other title calculated to induce a belief that they are registered.

Unprofessional advertising by medical practitioners can contribute to the increasing cost of provision of health services by promoting unnecessary treatments and increasing the associated risks of adverse events. The NCP Panel recommended restrictions on advertising designed to prevent unprofessional advertising by registered medical practitioners. The Panel formed the view that reliance on consumer protection and fair trading laws to regulate advertising of medical services did not provide sufficient protection to the public and that there was a net public benefit in empowering the Medical Practitioners Board to regulate this activity of medical practice. In addition, the Panel recommended implementation of the Victorian Law Reform Commission recommendations to empower the Board to require professional indemnity insurance as a condition of registration.

1. Review Objectives

The *Medical Practice Act* was passed by Parliament in 1994. It has provided a model for review of all other health practitioner registration Acts since that time. The Act protects the public by setting up the Medical Practitioners Board of Victoria and establishing statutory powers for the Board to regulate the profession. The Board is responsible for maintaining high standards of medical education and practice, as well as providing a mechanism for consumers to have any complaints against individual practitioners addressed.

In 1995 the Victorian Department of Human Services commenced a review of all practitioner registration legislation in Victoria. The National Competition Policy review of the *Medical Practice Act* was commenced in 1998 in conjunction with the NCP review of the *Nurses Act 1993*. The review was conducted in accordance with the 'in house review' model as described in the Victorian Government *Guidelines for Review of Legislative Restrictions on Competition*.(State Government of Victoria, National Competition Policy Guidelines, pp.4).

Terms of reference for the review are contained in Attachment 1.

The review addressed broader issues in addition to the restrictions identified under NCP. The four main objectives of the review were:

1. To ensure that the Victorian Government was able to meet its obligations under the Competition Policy Agreement, that is, to review and remove any unnecessary barriers to competition in Victorian legislation.

2. Specifically, to re-examine within the context of National Competition Policy, the restrictions on advertising that have been incorporated into all new health practitioner registration Acts since 1994.

3. To ensure that all health practitioner registration Acts contain a common core set of provisions governing the provision of health services by individual health practitioners as well as procedures for handling complaints and discipline.

4. To present for comment changes to the legislation proposed by the Medical Practitioners Board of Victoria.

Objective 1:

Under National Competition Policy, Victoria was required to review all existing legislation that imposes restrictions on competition by the year 2000. As part of this process, the Department of Human Services was required to review and, where necessary, reform all existing legislative restrictions on competition contained within health practitioner registration legislation administered by the Department. The guiding principle of the review was that legislation should not restrict competition unless it could be demonstrated that:

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

Restrictions on competition were identified in the *Medical Practice Act* and these were assessed against the above principles.

Objective 2:

One of the restrictions on competition that was identified was the regulation of advertising by registered medical practitioners. The advertising provisions in the *Medical Practice Act* have been used as a model for all health practitioner registration Acts passed in Victoria since 1994.

By issuing the discussion paper, and making it widely available to all interested parties including other health practitioner registration boards and their respective constituencies, the Department flagged its intention to review the standard provisions in health practitioner registration Acts which regulate advertising. It was expected that, if changes were to be recommended to the advertising provisions in the *Medical Practice Act*, as a result of this review, then amendments may also be required to all existing health practitioner registration Acts, to ensure consistency, and compliance with National Competition Policy.

Objective 3:

The *Medical Practice Act,* along with the *Nurses Act 1993* was one of the first Acts passed consistent with the Victorian model of health practitioner legislation. Therefore, it already contained the standard modern provisions required for all health practitioner registration legislation in Victoria. However, the review required under NCP provided an opportunity to:

- reassess the standard provisions with a view to ensuring that they will satisfactorily support and regulate practice into the 21st century;
- assess whether incremental changes that have been introduced with the passage of more recent health practitioner registration should be applied to nursing and medical practice legislation. More recent Acts with a number of updated provisions were the *Chiropractors Registration Act 1996*, the *Osteopaths Registration Act 1996*, the *Optometrists Registration Act 1996*, the *Podiatrists Registration Act 1997* and the *Physiotherapists Registration Act 1998.*

Objective 4:

The Medical Practitioners Board of Victoria proposed a number of amendments to the *Medical Practice Act 1994.* It was important that interested parties have an opportunity to examine and comment on these proposals. If such proposed amendments were to be adopted, then they would be expected to form part of the standard health practitioner registration model and other Acts might also require amendment.

2. NCP Panel and Review Process

A National Competition Policy Review Panel (NCP Panel) was set up to meet the requirements of the Victorian Government's National Competition Policy Guidelines. The panel consisted of three persons who were neither directly engaged in the medical profession nor in the regulation of that profession. They were:

Mr Robert Doyle MP	then Parliamentary Secretary to the Minister for Health
Ms Jan Norton	then General Manager Public Health & Development Division Department of Human Services
Ms Anne-Louise Carlton	then Project Manager, Health Workforce Section Public Health & Development Division Department of Human Services

The NCP Panel was responsible for conduct of the review and consultation, with advice and assistance from the Legislation and Legal Services Section of the Department of Human Services.

The review model determined under the *Guidelines for Review of Legislative Restrictions on Competition* was *Level 4: In-House Review* with a low scale/priority and no minimum consultation requirements. However, due to the potential for this review to establish precedents for amendments to other health practitioner registration Acts (see Objective no. 3), release of a discussion paper and conduct of a public consultation process were considered necessary.

In October 1998, the NCP Panel released a public discussion paper addressing the reviews of both the *Medical Practice Act 1994* and the *Nurses Act 1993* and advertisements were placed in The Age inviting submissions from the public. The paper was also available on the Internet (See Attachment 1). The purpose of this paper was stated as:

- To outline the guiding legislative principles of the National Competition Policy, to identify and review the restrictions on competition contained within the *Nurses Act 1993* and the *Medical Practice Act 1994*, and in particular, to examine whether there is a need for continued statutory registration of these professions, and how advertising should be regulated.
- If there is a sufficient case for continued statutory registration of nurses and medical practitioners, then to:
  - ⇒ Re-examine the model of legislative review that has been applied to health practitioner registration legislation in Victoria.
  - ⇒ Identify any changes introduced to the model of health practitioner registration since passage of the *Nurses Act 1993* and the *Medical Practice Act 1994*.
  - ⇒ Provide an opportunity for those who have an interest in the practice of nursing and medicine to comment on any proposed amendments prior to the preparation of separate draft bills.

The discussion paper set out:

- National Competition Policy considerations (Section 2).
- The key features of the model of regulation of health practitioner groups adopted by the Victorian Government, and any changes that have been introduced to the model since passage of the *Nurses Act 1993* and the *Medical Practice Act 1994* (Sections 3 and 4).
- The implications for the *Nurses Act 1993* and the *Medical Practice Act 1994* of recent changes to the standard model of health practitioner regulation.(Section 4)
- The reforms recommended by the Nurses Board of Victoria and the Medical Practitioners Board of Victoria (Section 5).
- The process of consultation, including how interested parties could obtain copies of this discussion paper and comment on the proposed reforms (Section 6).

The discussion paper summarised the main areas proposed for reform. In addition, submissions on matters not directly raised but which fell within the scope of the review were encouraged.

The key stakeholders involved in the consultation process included:

- Consumers of medical services
- Members of the medical profession
- The Medical Practitioners Board of Victoria
- AMA (Victorian Branch)
- Specialist medical colleges
- Hospitals, nursing homes and other health service providers
- Members of other health professions and their representative bodies.

Over 160 submissions were received and a summary of these submissions is contained in Appendix 1.

Following receipt of the NCP Panel's recommendations in March 1999, the Health Practitioner Acts Amendment Bill 2000 was prepared for introduction into Parliament. Following the election of the Labor Government in September 1999, a further round of consultations was held with key stakeholders, including the AMA and the Board. The *Health Practitioner Acts Amendment Act* was passed by the Victorian Government in May 2000, giving effect to the recommendations of the NCP review and other recommendations about changes to the model health practitioner registration provisions.

3. The Medical Services Market, Objectives of the Act, and Market Failure

3.1 The Medical Services Market

The Australian Institute of Health and Welfare publishes data on the characteristics of the medical labour force in its National Health Labour Force Series. In terms of overall numbers, the Australian medical labour force in December 1998 comprised 49,623 practitioners of whom 48,934 were employed and practising in medicine. Of this number, 12,074 were identified as practising primarily in Victoria. (Medical Labour Force Report No. 16 1998). As at 1st September 1998 there were approximately 14,500 medical practitioners holding general registration in Victoria.

Of the employed practitioners in Australia, 46,078 were clinicians and 2,857 were in non-clinical roles as administrators and educators, and in public health and occupational health. Of the clinicians, 20,1852 (45.3%) were primary care practitioners, 4,263 (9.3%) hospital non-specialists, 16,490 (35.8%) specialists and 4,473 (9.7%) specialists-in-training. The hospital non-specialist workforce is largely composed of doctors in training positions with currently 1,098 (25.8%) of them choosing hospital work as a career. A continuation of the postgraduate training pattern is expected to gradually decrease the proportion of primary care practitioners in the medical workforce and increase the proportion of specialists. (Medical Labour Force Report, pp 1).

The number of clinicians per 100,000 population was 244.5 in 1998. This compares with 209.5 in Canada in 1998 and 218.7 in New Zealand in 1997. There were 243.4 clinicians per 100,000 in Victoria, with a difference of 26.8% between the States and Territories with the lowest and highest supply. There were 87.5 medical specialists per 100,000 in Australia, with 96.6 in Victoria. (Medical Labour Force Report, pp 2).

Of the 5,316 primary care practitioners identified as practising in Victoria, the majority (4,500) were working in private rooms, with 459 in acute care hospitals, and smaller numbers in non-residential private facilities, aboriginal health services, other residential facilities, educational institutions and the Defence forces (Table 11). 4,817 were working in general practice, with 499 in a special interest area (Table 13). Of the 4,539 medical specialists practising in Victoria, the main specialties were Internal Medicine (1,143), Surgery (808), Psychiatry (628) and Anaesthesia (537). (Medical Labour Force Report, Table 16).

Examination of overseas trained doctors is conducted at the national level by the Australian Medical Council. In 1998, 669 overseas trained doctors presented to the Australian Medical Council for examination, and 220 successfully completed both the multiple choice questions and clinical components of the examination process (Medical Labour Force Report, Table 33). With the addition of 59 overseas trained practitioners accepted for registration via the specialist college pathway, a total of 299 additional doctors entered the medical workforce through this pathway.

There were 2,198 temporary resident doctors who entered Australia for employment in 1998. Most entered for a stay of less than 12 months. Of those 223 re-registered for practice at general renewal in late 1998.

In 1998-99, there was an average of 10.87 Medicare services provided per head of population, with 5.4 of these by general practitioners and 1.96 for pathology tests (Medical Labour Force Report, Table 41).

The extent to which there is substitution of demand and supply in the medical services market is variable. In metropolitan areas there are sufficient numbers of general practitioners and specialists to allow consumers to make choices between suppliers of medical services. In rural and remote areas, however, the difficulty in attracting medical practitioners means that consumers are significantly constrained in their choice of provider. In addition, there is some overlap in the provision of medical services, with other health professions providing services that to a certain extent can be substituted for medical services. These include chiropractors, osteopaths, physiotherapists, and various natural therapy providers such as naturopaths and Chinese medicine practitioners. Choice of services is significantly influenced by the availability of public subsidies via the Medicare and Pharmaceutical Benefits Schemes which affect the cost of medical practitioner services vis a vis other providers.

On the supply side, there are substantial constrains on substitution. Medical practitioner training is of 5 years duration with constraints on numbers of training places available.

3.2 The Objectives of the Medical Practice Act 1994

The main purposes of the *Medical Practice Act* 1994 are set out in section 1 of the Act. They are:

a) to protect the public by providing for the registration of medical practitioners, investigations into the professional conduct and fitness to practice of registered medical practitioners; and
b) to regulate the advertising of medical services; and
c) to establish the Medical Practitioners Board of Victoria and the Medical Practitioners Board Fund of Victoria; and
d) to repeal the Medical Practitioners Act 1970 and to make consequential amendments to other Acts; and
e) to provide for other related matters.

It is clear that the key objective of the *Medical Practice Act* is to protect the health and safety of the community. The Board is responsible for ensuring that medical practitioners meet certain professional standards of training and practice, with details of those standards to be determined by the Board and other specialist medical colleges. Registration of medical practitioners ensures that members of the public who require medical and hospital care can be confident that the person providing that care has a recognised qualification and has achieved a certain acceptable standard of practice, including:

- safe practice of the various medical procedures and thorough knowledge of how to minimise risks associated with these intrusive practices;
- safe prescribing of pharmaceutical medications;
- adoption of appropriate infection control procedures; and
- careful monitoring of health status and referral for specialist medical care where necessary.

The *Medical Practice Act* creates powers for the Board to:

- address patient complaints against registered medical practitioners including the conduct of investigations and hearings, and the imposition of sanctions where necessary.
- impose conditions, limitations or restrictions on the practice of registrants or deregister medical practitioners where necessary; and
- initiate action against any person who holds themselves out to the public as being registered to practice as a medical practitioner when they are not.

These safeguards operate to minimise the risks of harm to the patient.

3.3 Market Failure

Markets may fail to operate competitively or efficiently for a number of reasons, and these provide the principal rationale for government intervention. The need for and effects of government regulation must be assessed according to the extent to which it addresses such market failure and improves upon the outcomes of an unfettered market (National Competition Policy Guidelines for Review of Legislative Restrictions on Competition pp. 34).

Market failure in the provision of medical practitioner services is of two main types:

Externalities
The presence of negative externalities or spillover costs arises where medical procedures result in adverse events that require the provision of additional medical services and/or hospitalisation. In many cases, these spillover costs may not be borne by the original medical practitioner who provided the service. Regulation of professional conduct by a registration board is one way in which minimum safety requirements can be imposed on practitioners.

Information Asymmetry
Perfect competition assumes buyers and sellers have the same knowledge about product or service quality. However, in some markets, sellers have more information about quality than buyers. This may be because it would be prohibitively costly for consumers to acquire equivalent information prior to purchase (for example where a large amount of technical knowledge is required) or because quality can only be assessed after purchase and consumption (as is the case with most services). (National Competition Policy Guidelines for Review of Legislative Restrictions on Competition pp.38).

The relationship between patients (that is, consumers) and providers of medical services is characterised by knowledge discrepancies in favour of the provider. Patients are usually not as well informed as providers and they may lack the independent ability to judge the risks of alternative treatments (including non-treatment), the efficacy of medical products and services or the proficiency of the provider.

It is generally accepted that a market may fail to allocate resources efficiently when the relevant information for decision-making is distributed asymmetrically between market participants (that is consumers and providers). Therefore, government regulation may be warranted where there is a clear public interest at stake. While registration of practitioners restricts entry of suppliers to the medical services market, there is an imperative public interest justification for the registration of medical practitioners, where such registration minimises the risks to the public from inadequately trained practitioners carrying out

intrusive and potentially harmful therapeutic procedures. The regulatory experience in Australia and overseas is that governments have traditionally relied on professional regulation as a quality-control mechanism that restricts the practice of medicine (with its attendant health risks) to persons with recognised training and competencies.

4. Legislative Restrictions on Competition in the Medical Practice Act 1994

4.1 Registration Restrictions -Background

The NCP Panel identified a number of existing legislative provisions that had potential to impede competition by directly constraining consumer choice. The provisions requiring registration of practitioners are, in themselves restrictions on competition since they establish barriers to entry to the profession. The qualifications and training requirements imposed constitute restrictions on the numbers of people who may enter the market to offer medical services. If there were no statutory framework for the regulation of the medical profession, then protection of the public would rely on voluntary self-regulation by the profession and employer responsibility for the quality of services their employees provide.

The Panel requested submissions on whether self-regulation is a viable alternative for the provision of medical services and what might be the impact of deregulation.

If compulsory registration of medical practitioners was to be retained, then a net public benefit must be demonstrated. The key questions addressed were:

- What are the risks associated with the practice of medicine?
- What are the benefits of statutory occupational regulation?
- Are there alternative and less restrictive methods of protecting the public than statutory registration?
- Would the public be exposed to an unacceptably high level of risk if a less restrictive form of regulation was adopted?

4.2 Findings and Recommendations

The NCP Panel concluded that there is a range of risks associated with the practice of medicine and that there was a net public benefit in retaining the registration requirements and restrictions on use of professional titles. In addition, statutory registration of the medical profession is the gate-keeping device that provides a basis for implementation of a range of other regulatory and funding systems, such as Medicare, the Pharmaceutical Benefits Scheme and interstate and trans-Tasman mutual recognition schemes.

The alternatives for occupational regulation of any health profession include:

- Self-regulation by the profession
- Legislative registration - protection of title only
- Legislative registration - protection of title and restriction of practice.

Difficulties with self-regulation have been canvassed as part of the review of currently unregulated health occupations such as Chinese medicine practitioners, and in the context of the review of the *Health Services (Conciliation and Review) Act 1989*. These difficulties include:

- Reliance solely on self-regulation is problematic where practices of the profession present potentially serious risks to public health and safety. These problems have been

documented in various government reports, specifically the Victorian Ministerial Advisory Committee report *Traditional Chinese Medicine Report on Options for Regulation of Practitioners*, and the NSW Joint Committee on Health Care Complaints Committee report *Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints*. For example, where there are no statutory powers to restrict entry to the profession, those with minimal or no qualifications can set up practice and use the titles of the profession without meeting acceptable minimum standards of training and practice. In currently unregistered professions such as counselling and complementary and alternative therapy, this has led to widely varying standards of practice and levels of qualifications, substantial fragmentation of the professions, and no widely recognized and accepted peak professional bodies. Furthermore, under such self-regulatory systems, there have been few effective methods of enforcing compliance by training public and private institutions with educational standards determined to be acceptable by a profession.

- There is potential for conflict of interest in the operation of self-regulatory schemes. Some professional associations have close links with or have been established specifically to recognise graduates of particular training institutions and provide certification only for those graduates. These links are not always transparent (Bensoussan and Myers, 1996:136-137).
- Complaints mechanisms can also be compromised under self-regulatory approaches. The office bearers of professional associations are generally elected by members of the association rather than appointed by an independent process. Without sufficient independent and non-profession specific input into the certification, complaints handling and disciplinary processes, there is scope for professional interests to take precedence over the public interest. In addition, associations report threats of litigation from practitioners who are requested to attend an informal hearing of a complaint. (Australian College of Acupuncturists, 1994:2).
- Finally, legal rights to prescribe and supply drugs and poisons that are restricted under State and Territory drugs and poisons legislation rely on a statutory registration system. A self-regulation system is unlikely to provide sufficient controls or government and consumer confidence to allow access to prescribing rights.

The provisions of the *Medical Practice Act* do not restrict any of the following:

- the practice of medicine by any registered or unregistered practitioner (provided they do not hold themselves out to the public as being qualified and registered or adopt certain protected titles);
- the number of individuals being trained in University courses;
- the number of individuals able to enter the profession after achieving appropriate qualifications; and
- the practice of aspects of medicine by other registered or unregistered occupational groups such Chinese Medicine Practitioners.

There was widespread industry and community support for maintenance of minimum standards via registration of medical practitioners. In summary, the Panel was of the view that self-regulation by the industry would not adequately protect the public, because:

- consumers have serious difficulties in determining independently, the validity of professional qualifications and/or standards of practice;
- there are potentially serious social and economical costs associated with provision of services by medical practitioners who are not properly qualified;
- a range of other regulatory systems rely on statutory registration of medical practitioners. For example, in order to claim professional titles and carry out statutory roles under the *Medicare Act*, the *Drugs Poisons and Controlled Substances Act*, and other State and Commonwealth Acts, the medical practitioner must be registered with the Board.
- Mutual recognition arrangements between States and Territories, along with Trans Tasman mutual recognition rely on statutory registration systems in each jurisdiction.

The NCP Panel concluded that:

- there are significant risks associated with unregulated practice of medicine;
- there is not sufficient evidence to justify introduction of a definition of medical practice and additional restrictions in the *Medical Practice Act* on who can provide medical practitioner services;
- the least restrictive method of ensuring that the public is protected from unsafe medical practice is to retain the legislative restrictions on who can use certain professional titles.

The Panel recommended retention of the existing medical practitioner registration system based on protection of title, with an independent statutory Board made up of a majority of highly qualified members of the medical profession plus lay and legal representation.

4.2 Provisions to Regulate Advertising by Medical Practitioners

4.2.1 Background

The model advertising provisions were contained in the *Medical Practice Act 1994*. They prohibited advertising which:

- is false, misleading or deceptive;
- offers a discount, gift or other inducement to attract patients unless the advertisement also sets out the terms and conditions of the offer;
- refers to, uses or quotes from testimonials or purported testimonials; or
- unfavourably contrasts medical or surgical services provided by one practitioner with services provided by another.

Penalties vary depending on whether the practitioner is an individual or part of a body corporate. The same provisions have been incorporated into the following health practitioner registration legislation:

- *Optometrists Registration Act 1996*
- *Osteopaths Registration Act 1996*
- *Chiropractors Registration Act 1996*

- *Podiatrists Registration Act 1997*
- *Physiotherapists Registration Act 1998*

The NCP Panel sought comment on the standard advertising provisions as contained in the *Medical Practice Act* with a view to determining whether the net benefits of restricting advertising by the health professions outweighed the costs, and whether the standard provisions should be introduced in the *Nurses Act 1993* and other health practitioner registration Acts.

The discussion paper outlined arguments for and against powers for health practitioner registration boards to regulate advertising by their registrants. These arguments are set out below:

Arguments for limiting the powers of health practitioner registration boards in relation to advertising:

- Advertising is about the dissemination of information. Restrictions on advertising that exacerbate the fundamental disparities in market information can eliminate or constrain normal forms of competitive behaviour. Such restrictions can deny consumers normal forms of information about the availability, quality and price of services provided by competing practitioners, and therefore have adverse effects on efficiency, costs and prices.

- Consumers very rarely make complaints to the Medical Practitioners Board, for example, about advertising. Complaints received are generally from other registered medical practitioners arguably prompted by commercial rivalry rather than concern with quality of care and protection of consumers.

- The advertising provisions in the *Medical Practice Act* and other Acts duplicate unnecessarily, the powers of other bodies, for example:

    - false, misleading and deceptive advertising powers may be more effectively dealt with under State and Commonwealth trade practices and fair trading legislation. Fines of up to $50,000 can be imposed under the *Fair Trading Act 1985*, as compared with fines of up to $5,000 for a natural person and $10,000 for a body corporate under the *Medical Practice Act*.

    - the disparaging comments provision may be adequately covered by the law of libel and, it is argued, may act to protect professionals more than it protects the public.

    - abuses in advertising which refer to testimonials that are false or misleading may be covered by law of fraud and fair trading legislation.

- The Medical Practitioners Board and other health practitioner registration boards have encountered difficulties in enforcing the advertising provisions due to the length of time taken to receive and investigate a complaint and then refer it to the Magistrates Court for action and the impact of the 12 month Statute of Limitations.

- The Medical Practitioners Board and other health practitioner registration boards have existing powers under the provisions relating to 'unprofessional conduct' to investigate and discipline practitioners whose advertising breaches the standards expected by the community and by their peers.

Arguments for strengthening the powers of health practitioner registration boards to regulate advertising:

- The registration boards are in many cases the most suitable bodies to discipline their members for unprofessional advertising since they are more closely involved on a day-to-day basis with the professions than are other regulatory bodies such the Office of Fair Trading and Business Affairs or the Australian Competition and Consumer Commission (ACCC). They may, therefore, be better equipped to identify and deal with the less serious examples of unprofessional or dishonest advertising that the ACCC and the Office of Fair Trading may not have the resources to deal with effectively.

- The sanctions that registration boards have available are very immediate, direct and timely. A practitioner at risk of losing his/her livelihood is most likely to take notice of Board, particularly when the Board is made up of their peers. Civil courts do not have the power to prevent a practitioner from practising his or her provision.

- To abandon or restrict further the powers of registration boards to regulate advertising might effectively shift the costs of such regulation from the private sector to the public sector. That is, the regulatory role of registration boards is funded via the annual registration fees levied on registered practitioners. If the Office of Fair Trading, the Health Services Commissioner or other Government funded bodies were to deal with complaints traditionally dealt with by registration boards, then there would be increased demand on public sector resources.

- To abandon restrictions on use of testimonials in advertising may lead to a flood of potential abuses which are likely to be very costly for a registration board to investigate and prosecute, with questionable improvements in access to information for consumers on which to make informed health care choices.

The Health Care Complaints Commissioner of NSW, Ms Merrilyn Walton in her submission to the NSW Parliament's Joint Committee on the Health Care Complaints Commission has commented on the difficulties that arise when the Commission refers matters to other bodies for prosecution. These include pursuing prosecutions under the NSW *Fair Trading Act 1987*, when medical services are treated as a commercial product. (HCCC Submission to the NSW Parliament's Joint Committee on the Health Care Complaints Commission, 28 May 1998).

Ms Walton has argued that fair trading and other similar legislation is generally inaccessible to most health care consumers and accordingly is not an appropriate mechanism for maintenance of professional standards (NSW Health Department Issues Paper, Review of Medical Practice Act 1992, September 1998 pp 72).

The Royal Australian College of Ophthalmologists (RACO) made a submission the Department in support of strengthening the current powers of the Medical Practitioners Board to regulate the advertising practises of registered practitioners. They argued that:

- the advertising powers in Victorian legislation are already the least restrictive of all Australian States and Territories, and that there are many instances of unprofessional or false and misleading advertising that the Board does not have the power to prosecute.

- the current regulations are in fact anti-competitive, against the public interest, and allow advertising which reduces the overall sense of medical professionalism in the eyes of many doctors and of the public. (Submission from RACO. 18 August 1997 pp.3-6).

4.2.2 Findings and Recommendations

The NCP Panel recommended amendment to the advertising provisions in the *Medical Practice Act* as follows:

- Removal of the restriction on advertising that prevents practitioners from unfavourably contrasting the services of another practitioner;
- Inclusion of a restriction on advertising that creates an unreasonable expectation of beneficial treatment;
- Retention of restrictions on false and misleading advertising, offering gifts and discounts without setting out the conditions of the offer, and use of testimonials or purported testimonials.

The Panel therefore recommended adoption of the following restrictions on advertising by registered medical practitioners and bodies corporate employing medical practitioners:

> *'A person must not advertise in a manner which:*
> 1. *is or is intended to be false, misleading or deceptive; or*
> 2. *offers a discount, gift or other inducement to attract patients to a practice unless the advertisement also sets out the terms and conditions of that offer; or*
> 3. *refers to , uses or quotes from testimonials or purported testimonials.*
> 4. *creates an unreasonable expectation of beneficial treatment; '*

The Panel considered these advertising provisions to be the least restrictive provisions desirable to protect the public, in addition to those avenues of redress available through the ACCC and the Office of Fair Trading. The Panel also recommended that these provisions be introduced as standard powers for all health practitioner registration boards.

False and Misleading Advertising and offering gifts and discounts without setting out terms and conditions
The main provisions reflect those contained in the *Trade Practices Act*, and were proposed as standard provisions to be adopted in all Victorian health practitioner registration legislation.

Advertising that unfavourably contrasts the services of another medical practitioner
The Panel recommended repeal of this restriction on competition for the following reasons:

- there was not sufficient evidence to suggest the public would be at risk if the restriction was removed;

- this restriction primarily appeared to protect the profession rather than the public; and
- there are other avenues of redress available to those aggrieved by such advertising, in particular the laws of defamation.

Use of testimonials in advertising
This provision makes clear that it is an offence for a registered medical practitioner to use testimonials or purported testimonials to advertise their services. In recommending retention of this restriction on advertising, the arguments accepted by the Panel were as follows:

- choice of medical services should be on the basis of professional competence and referral from other qualified health practitioners;
- testimonials are generally unsubstantiated claims made by those who may not be qualified to make such claims;
- testimonials may be made in response to financial incentives, and may adversely influence an individual's ability to make informed decisions concerning choice of practitioner and quality of service. Restrictions are therefore required.

Power for the Board to issue Guidelines
The Panel also recommended a role for the Medical Practitioners Board in issuing guidelines on what constitutes acceptable advertising by medical practitioners in order to further clarify the provisions of the legislation. This was in response to concerns raised by officers from the Departments of Treasury and Premier & Cabinet about the potential for difficulties in interpretation by courts of the generally worded provisions restricting advertising. Such guidelines **may** be taken into account by a court in determining whether an offence has been committed under the Act.

Advertising that creates an unreasonable expectation of beneficial treatment
The main arguments accepted by the Panel in favour of retaining such restrictions on advertising by registered medical practitioners are summarised as follows:

- the market for medical and health services should have more stringent advertising controls than other markets, due to the information asymmetry which exists in the doctor-patient relationship, and the potential adverse consequences and cost to the community of provision of unnecessary or poor quality health care (see submissions from Victorian Health Services Commissioner and NSW Health Care Complaints Commissioner re case-studies on problems with aggressive advertising of cosmetic surgery and laser eye surgery);
- existing avenues for regulating advertising are not sufficient or effective enough to protect the public in this area given the risks;
- all submissions raised concerns about the risks to the public from the significant increase in 'entrepreneurial activities' by medical practitioners, and reinforce that the demand for and supply of medical services should not be considered the same as that of other consumer goods;
- precedents exist in Trade Practices law that indicate that medical advertising that is factually incorrect and/or misleading about the benefits of treatment is not necessarily found to be false, misleading or deceptive;
- given the potential for serious harm to patients from unnecessary medical procedures, advertising of medical services should reflect high professional standards;

- controls on advertising regulated by the Board are considered to reduce the risk of the public being misled by false claims to medical products and services;
- determination of professional standards in the interests of public health should not be frustrated by the law;
- further deregulation of advertising is not expected to improve access to cheaper or better quality services;
- the Commonwealth *Therapeutic Goods Act* and other State and Territory health practitioner registration Acts recognise the importance of more stringent controls on advertising in the health services market than are in place in other markets;
- there are strong public benefit reasons for strengthening restrictions on advertising in medical and health services and these outweigh the costs to the community from such restrictions.

Net public benefit in retaining restrictions on advertising:
The Panel was of the view that there is a net public benefit in retaining some restrictions on advertising regulated by the Medical Practitioners Board. The Health Services Commissioner (HSC) reported receiving multiple complaints about some medical procedures, in particular cosmetic surgery and that a common feature of these complaints was that the consumer decided to have the procedure following aggressive advertising:

> *The use of 'advertorials' in weekend newspapers, in particular, features potentially misleading advertising. These kinds of advertisements raise expectations which are often not fulfilled and patients have been damaged physically and emotionally.*
>
> *The performance of services like eye surgery cannot be equated with the purchasing of consumer goods. The consequences of failed procedures are extremely grave and can include blindness.*

The Health Complaints Commissioner in NSW has raised similar concerns, highlighting the problems of unregulated advertising in the *Report of the Ministerial Committee of Inquiry into Impotency Treatment Services in NSW.* The report highlighted the risk to patients from advertising by services that promoted self-referral to symptom-specific clinics. There is a growing body of evidence pointing to the need for increased controls of the activities of such clinics, including their advertising practises.

The HSC acknowledges that State and Commonwealth trade practices and fair trading legislation should be able to deal with these problems.

> *Unfortunately, these mechanisms tend to be inaccessible to most health care consumers and accordingly is not a complete mechanism for maintenance of professional standards.*

The HSC considers that there is a net public benefit in strengthening powers of the registration Boards to regulate advertising.

Advertising of medical services is a professional standards matter and the overwhelming view of the profession should be given due consideration:
There was overwhelming support for strengthening of the current restrictions on advertising, not only from the specialist medical colleges and professional associations but also from

community organisations and complaints bodies. These organisations urged a recognition that medical services are different from other services and that the proper exercise of professional judgements in the best interests of patients should be reflected in advertising of medical services. Justice Winneke reflects this view in his paper *Appeals from disciplinary tribunals: does law or medicine set the standards?* Justice Winneke stated he had:

> *come to learn of the wisdom of leaving to senior members of a profession the task of setting and maintaining standards which are expected to be followed by the members of the profession..... (it is) eminently desirable that professions, through their members, should set their own professional standards. It is undesirable that, in the performance of that task, professional bodies should be frustrated by the law.*

Complaints about advertising are motivated by genuine concerns about risks to the public:
The AMA and the Australian College of Dermatologists maintain that complaints from medical practitioners to the Board concerning advertising are not motivated by commercial rivalry.

> *Medical practitioners make complaints about advertising because they know of the legislative requirements and are aware of the potential harm to the integrity of the profession and the doctor-patient relationship where breaches occur. Medical practitioners are also able to exercise their professional judgement about realistic expectations, whereas the public may be unable to assess the veracity of the claims that are made. Consequently, complaints lodged by doctors are usually based on a belief that the public is at risk or are being misled, rather than any commercial motivation.*

Further deregulation of advertising will not lead to better access or lower cost higher quality medical services:
The AMA submission stated that under current arrangements:

- there is vigorous price competition between GPS, with about 75% of their services bulk billed; and
- patients routinely share information with their family and friends about their perceptions of the quality of care they receive.

Consequently, the AMA argued that further deregulation of advertising will not improve patient access to quality general practice care, nor drive down its cost. With respect to specialist care, the huge information asymmetry between specialist and patient is well known, and cannot be corrected by less restrictive advertising.

Advertising bypasses the important role of the General Practitioner:
Particular concerns were raised about the risk to patients from advertising that promotes self-referral to symptom-specific clinics. Submissions identified the key and beneficial role of the general practitioner (GP) as the gatekeeper in the Australian health care system. Advertising by such clinics has enabled entrepreneurs to encourage the public to circumvent the traditional channels of referral through the GP into the specialist system. This traditional pathway allows the provision of considered and unbiased advice by the GP, which reduces the likelihood the patient will unquestioningly accede to costly, unnecessary or ineffective treatment.

The AMA stated:

> *Medical practitioners are able to exercise their professional judgement about realistic expectations, whereas the public may be unable to assess the veracity of the claims that are made. Therefore, rather than improving the information asymmetry inherent in the doctor-patient relationship, advertising that encourages direct self-referral in fact worsens the asymmetry.*

Concerns about the increase in 'entrepreneurial' medicine and the marketing of medicine as a commercial product:

The AMA pointed to increasing concerns about advertising of medical services since deregulation.

> *Advertising by its very nature tends to be sensational and is driven by financial imperatives. Since the current Act was proclaimed, large-scale advertising of medical services has overwhelmingly been used to promote new procedures and technologies. Often procedures do not attract Medicare rebates, presumably because the Commonwealth believes that they are unproven or only provide marginal public benefit.*

The Royal Australasian College of Surgeons stated:

> *professional expertise, particularly in the surgical disciplines, should not be marketed like commercial goods or household items. The standard of surgical practice and clinical outcomes are much more likely to be less than satisfactory when the commercial aspects of practice take precedence over professionalism.*

The Ontario model of regulation of advertising outlined below is seen as encouraging the dissemination of information but also protecting the public. The rules permit members to communicate any factual, accurate and verifiable information that a reasonable person would consider material in the choice of a medical practitioner. Such provisions are seen as dealing with the evolving problems linked to the entrepreneurial promotion of specific services and treatments, which may prove detrimental to specific patients or the community as a whole.

Other jurisdictions are increasing restrictions on advertising of medical services:

At the time the review was conducted, Victoria had the least restrictive advertising provisions of any jurisdiction in Australia, and there were no indications that other States and Territories intend to further deregulate advertising. Other jurisdictions, both in Australia and overseas, have more restrictive advertising provisions than those currently in force in Victoria, and the trend is towards increasing regulation of this area. For example, in Ontario Canada, the following restrictions have been introduced in response to the increasing concerns about medical advertising:

- medical practitioners can advertise in any medium available to all other practitioners;
- the information advertised must not be false or misleading;
- the advertisement cannot contain testimonials, or comparative or superlative statements;
- medical practitioner advertising must not be associated with the advertising of products or services;

No medical practitioner is permitted to:

- allow his/her name to appear in any communication offering a product or service to the public; or

- allow him/herself to be associated with the advertising or promotion of any product or service, other than the medical practitioner's medical service in accordance with the above principles; or
- participate directly or indirectly in a system in which another person steers or recommends people to a medical practitioner for professional services unless it is done honestly and with no conflict of interest.

In NSW, the advertising restrictions in the *Medical Practice Act* include the following restrictions:

> *a person may advertise medical services in any manner except that which is false, misleading or deceptive or creates an unjustified expectation of beneficial treatment or promotes the unnecessary or inappropriate use of medical services.*

Commonwealth Therapeutic Goods Act restricts advertising:
The Commonwealth *Therapeutic Goods Act* prohibits the advertising directly to the public of substances that can only be obtained on prescription. This rule is to prevent pharmaceutical companies from making unrealistic claims to the public at large, which has no knowledge of pharmacokinetics and could be influenced by ambiguous claims of drug efficacy. It appears that the Commonwealth, not withstanding that pharmaceutical companies are bound by the advertising provisions of the *Trade Practices Act*, has determined that the risk to the community is too great to allow this form of direct promotion to the public. The AMA and other professional associations and specialist colleges have argued that a similar standard should apply to the advertising of medical services generally.

Inadequacy of other avenues for regulating advertising of medical services:
The Health Services Commissioner and specialist medical colleges have pointed to examples where the existing avenues for regulating advertising of medical practitioners are unsatisfactory or ineffective. In particular, the Australasian College of Dermatologists included details of a matter referred to the Australian Competition and Consumer Commission that was then further referred to the Office of Fair Trading because of lack of jurisdiction. The matter raised serious concerns and was at the time of reporting, still not resolved.

Rather than unnecessary duplication of regulation, other avenues via the laws of libel and fraud are seen as more complex and expensive than parallel provisions in the *Medical Practice Act*. The ACCC and the Office of Fair Trading are seen as having limited resources to prosecute breaches and only those most blatant offences are acted upon. In addition, they apply a different standard to assess what constitutes 'false and misleading' advertising than that which a health practitioner registration board concerned with professional standards might apply. For example, the AMA points to the following problems:

- the Trade Practices Commission in its booklet, *Advertising and Selling: A business guide to consumer protection under the TPA* holds that 'puffs', the use of superlatives and comparatives, are self-evident exaggerations and are unlikely to mislead anyone;
- Courts have found that mere proof that behaviour has caused confusion or uncertainty in the minds of the public will not suffice to prove misleading or deceptive conduct; and
- an expression of an opinion will not constitute misleading or deceptive conduct if the person honestly believes what he has said.

The AMA submitted that *'If sections 64 (1) (c&d) are repealed, then at the margins of medical practice, we must expect that there will be advertising that resorts to puffery and testimonials, surely the antithesis of evidence based medicine. On precedent, it is arguable that neither the Board or indeed the Courts could find such behaviour was false, misleading or deceptive, even if it was not factually correct'.*

While there may be only a small proportion of consumers of health services who are deceived by advertising that resorts to 'puffery and testimonials', there may be high costs associated with any adverse incidents.

Unique role and position of registration boards to regulate advertising:
Registration Boards, with appropriate specialist input, are considered suitable bodies to assess advertisements for medical practitioner services and to implement sanctions where necessary. The Medical Practitioners Board maintains that by virtue of its central role of protecting the public, it is able, in many cases, to persuade an errant practitioner, via peer pressure and the threat of disciplinary action, to change the offending aspects of an advertisement and thus obtain an expeditious and cost-efficient outcome. In 1997, the Board received 18 complaints about advertising, of which only two progressed to an informal hearing, with one adverse finding of unprofessional conduct. In all instances, where a breach was found, the offending advertising was immediately corrected.

The Victorian Office of Fair Trading in its submission acknowledged the overlap in jurisdiction between the Board and the Office. However, it stated that since August 1996 the Office has received only three complaints against medical practitioners, all of which were forwarded to the Medical Practitioners Board. Their submission stated *'it is acknowledged that the Medical Practitioners Board is more closely involved with the profession and would therefore appear to be better equipped to identify and deal with breaches of the Medical Practice Act'.*

Widespread support for retention of restrictions on advertising:
The question of advertising by medical practitioners and what restrictions should be retained was thoroughly canvassed as part of the consultation process. All other health practitioner registration boards and their respective professional associations were invited to make comment on this issue, along with other interested parties and the community. Five registration boards supported retention and in most cases strengthening of the current restrictions on advertising. The AMA vigorously opposed any further weakening of the restrictions on advertising, as did the Health Services Commissioner (HSC) and the professional associations representing other registered health occupations (with the exception of the Chiropractors Association of Victoria). The strongest opposition to removing restrictions on advertising has come from the AMA and the specialist medical colleges, including:

- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Psychiatrists
- Australian College of Dermatologists (Vic)
- Royal Australasian College of Medical Administrators
- Royal Australian College of Obstetricians and Gynaecologists

4.3 Accreditation of Intern Training Positions by the Medical Practitioners Board

4.3.1 Background

Section 95 of the *Medical Practice Act 1994* provided the Medical Practitioners Board of Victoria with the power to approve positions in hospitals or institutions for intern training. The Board also had the power to impose conditions, limitations or restrictions on any such approval.

Part 6 Division 2 of the *Medical Practice Act* established the Intern Training Accreditation Committee with powers to advise the Medical Practitioners Board on intern training, receive and consider applications for approval of intern training positions in hospitals and other institutions, periodically review approved positions and make recommendations as to whether approval of positions should continue. This arrangement was designed to ensure that minimum standards are met for provision of intern training positions.

The Department of Human Services provides sufficient funding each year to guarantee intern training positions for all Victorian trained medical graduates. Under these arrangements, hospitals can only offer an internship approved by the Board and their ability to create intern positions for graduates from interstate or overseas is restricted due to the costs

The NCP Panel sought comment on whether there was a net public benefit in retaining restrictions on approval of intern training positions by the Medical Practitioners Board.

4.3.2 Findings and Recommendations

The NCP Panel found that the Board's role in approving intern training positions did not constitute a restriction on competition for the following reasons:

- The Board's role is to approve the standard of training available to interns in approved positions, but not to determine the overall numbers of positions available.
- The primary restriction on the availability of intern training positions is in the form of limitation of funding made available by the Department of Human Services to pay for intern training positions.
- Each intern training position costs approximately $35,000 per annum. Hospitals are at liberty to find funding from within their own budgets for additional training positions and seek accreditation of these positions with the Board. In practice this does not happen, but this is due to budgetary constraints rather than restrictions imposed by the Medical Practitioners Board

The Panel did however, recommend repeal of sections of the Act that establish the role, function and membership of the Intern Training Accreditation Committee in order to facilitate the establishment of an independent Postgraduate Medical Council of Victoria with a broader role in provision of training, accreditation and education for medical practitioners in their postgraduate years 1, 2 and those in year 3 who are not enrolled in an accredited specialist college training program.

4.4 Powers for the Board to require Professional Indemnity Insurance

4.4.1 Background

The question of compulsory professional indemnity cover was thoroughly canvassed in the Interim Report of the Commonwealth Review of Professional Indemnity Arrangements for Health Care Professionals, titled *Compensation and Professional Indemnity in Health Care* (the Tito Report) published in February 1994. The Final Report, published in November 1995, made the following recommendations:

> *On balance, the Professional Indemnity Review considers that there are strong public policy reasons to support government legislation requiring all health professionals, who have the potential to cause significant harm to their patients, to have adequate professional indemnity cover as a condition of practice.* (Recommendation 128)
>
> *Similarly, the PIR recommends that all health care businesses, including private hospitals, day surgery facilities, pathology services and health centres which provide services to patients, that have the potential to cause significant harm, also have adequate professional indemnity cover or be required to demonstrate sufficient financial reserves to be able to meet any probable maximum loss arising from negligence in service provision. A combination of self-insurance and catastrophe cover could also be suitable, where financial reserves were sufficient.* (Recommendation 129).
>
> *The PIR recommends that the Commonwealth and states through AHMAC develop an agreed strategy for making professional indemnity cover (with a defined set of minimum set of characteristics) compulsory for all health professionals, either through their own cover or through adequate cover by their employer, in the case of vicarious liability* (Recommendation 132).
>
> *The PIR further recommends that this strategy should aim primarily at developing nationally consistent legislation to be passed in all states, but that if this does not seem likely to occur, the Commonwealth should act within the full scope of its constitutional powers to ensure that this is a requirement for all health professionals in Australia.* (Recommendation 133).

In 1997, the Law Reform Committee of the Parliament of Victoria published a report titled *Legal Liability of Health Service Providers*. Recommendation 5 of the report stated:

> *Statutorily recognised health service providers should be required to obtain compulsory professional indemnity insurance cover with respect to privately funded patients, in order to become and remain registered. The minimum level of cover should be specified by the appropriate registration board, in consultation with relevant professional associations. Runoff cover should be provided for those who are currently insured on a different basis to the mandatory requirement.*

This recommendation was implemented by the Victorian Government with the passage of the *Physiotherapists Registration Act 1998.* Under sections 4(2)(c), 6(3)(a), 7(2)(b), and 11(1)(b) of that Act, the Board has the power to require evidence from registrants of adequate

arrangements for professional indemnity insurance as a condition of initial registration and renewal of registration. Where the registrant is an employee, then a statement from their employer concerning their professional indemnity arrangements would be required by the Board.

The NCP Panel sought comment on whether the Medical Practitioners Board should have the power to require evidence of satisfactory arrangements for professional indemnity insurance as a condition of registration. The Panel noted that no restrictions exist on the provision of this indemnity cover with some private insurance companies now entering the market previously dominated by a small number of medical defence organizations (MDOs).

4.4.2 Findings and Recommendations

The NCP Panel accepted that the vast majority of medical practitioners, including vocationally registered general practitioners and medical specialists hold indemnity cover with one of a number of medical defence funds. Where they are employed in the hospital system, they are also covered by their employers' insurance arrangements. Insurance arrangements are required in order to be vocationally registered as a general practitioner or to take out membership of bodies such as the specialist medical colleges or the AMA.

However, the Panel accepted that there are a small number of practitioners, primarily non-vocationally registered general practitioners who are not members of these bodies and may have inadequate professional indemnity or insurance cover or no cover at all. The Panel concluded that there was sufficient evidence of disadvantage to patients from uninsured doctors and the failure of less restrictive approaches to recommend adoption of powers for the Medical Practitioners Board to require evidence of satisfactory arrangements for professional indemnity insurance as a condition of registration of medical practitioners. This evidence was in the form of:

- recommendations from the Tito Interim and Final Reports and the Victorian Law Reform Commission Report on Legal Liability of Health Service Providers;
- submissions to the Panel from the Plaintiff Lawyers Association and various registration boards concerning cases where practitioners were found guilty of medical negligence, had failed to take out insurance cover, declared themselves bankrupt and avoided paying court ordered settlements.

The Panel did not accept arguments that registration requirements for compulsory cover would be difficult to implement and administer. The Panel also recommended that these provisions be introduced as standard powers for all health practitioner registration boards.

5. Summary of Costs and Benefits

The costs and benefits of registration of medical practitioners are difficult to quantify. There is no unregulated market with which to make comparisons since all Australian States and Western countries appear to have similar registration schemes that control entry to and practice of the profession.

In relation to the costs and benefits of compulsory professional indemnity arrangements, there is no firm data on the number of practitioners not currently protected by indemnity/insurance arrangements or the number of uninsured losses that have arisen. Such information is very difficult to access. However, in response to concerns about loss of obstetric services in rural and remote areas due to the high cost of insurance, in 1998 the Victorian Government introduced a subsidized insurance scheme for country GPs.

Society places a high value on human life and does not tolerate the avoidable risk of serious injury or death from provision of unprofessional or incompetent medical services. It is considered socially unacceptable for individuals to unknowingly place themselves at risk from poor standard medical services. It is estimated that 16.6% of Australian hospital admissions resulted in an adverse event caused by health care management (Wilson et al 1995). Such a figure would be expected to increase if controls over the standard of training and practice of medical practitioners were to be removed, as would the associated costs additional medical treatment, patients' loss of income through extended hospitalisation etc.

The main benefits of regulation of medical practitioner services are:

- greater assurance of service quality;
- improved information to facilitate informed consumer choice;
- reduced risk of illness, injury or fatality;
- reduction of fraudulent or opportunistic behaviour.

The NCP Panel considered that:

- alternative methods of regulation would not adequately protect the public, and
- would in some cases breach Victoria's obligations under interstate and Trans Tasman Mutual Recognition arrangements, and
- the legislative provisions were the minimum necessary to provide a satisfactory level of protection to the community, and
- there was no other non-legislative way of achieving the objectives of the legislation.

The costs and benefits for the key stakeholders were identified as follows:

Consumers of medical practitioner services:

Costs: The cost of registration and of professional indemnity insurance is passed on to consumers in the form of more expensive medical services. Registration fees are set at $300 per annum. In relation to professional indemnity insurance, most medical practitioners already have indemnity cover through one of a number of medical defence organizations or work in settings whether their employer's insurance arrangements would cover professional indemnity requirements. Therefore additional costs are unlikely.

There may be costs associated with restricting information to consumers through the regulation of advertising.

Benefits: Access to an industry that is appropriately regulated by professionals who are qualified to determine appropriate professional conduct and impose sanctions This ensures that those who provide medical services are sufficiently well qualified to provide safe medical services & increases consumer confidence.

Access to a complaints mechanism for instances of unprofessional conduct by registered medical practitioners. Practitioners who are not competent to practice can be deregistered or required to undergo further training or have conditions attached to their practice to protect the public. The standard of practice by all registered medical practitioners is maintained, with expected flow on health benefits to consumers. A finding against a medical practitioner of unprofessional conduct of a serious nature can facilitate settlement of medical negligence claims.

Reassurance that persons practising medicine are appropriately qualified and have adequate professional indemnity insurance without needing to personally check their qualifications.

The quality of information made available to consumers via patient testimonials and unethical advertising practices has been shown to create unnecessary demand for health services that can harm patients and cost the community in additional health services, for example in areas such as cosmetic surgery, impotence treatment and laser eye surgery.

Members of the medical profession:

Costs: Prospective entrants to the industry must undergo a recognised training course and be accepted for registration before providing medical practitioner services to the public.

Benefits: Regulation of the industry by qualified practitioners allows the adoption of appropriate standards and practices and sanction of individuals engaging in inappropriate care.

Protection of professional status by:

- preservation of the title;
- restrictions on other statutory responsibilities which rely on statutory registration to identify suitably qualified practitioners, such as prescribing rights under the *Drugs Poisons & Controlled Substances Act.* Regulation of the industry by a qualified Registration Board allows the adoption of appropriate standards and practices and sanction of individuals engaging in inappropriate care.

Protection of professional status by preservation of the title rather than restrictions on practice that limit other workers within the health system is the least restrictive approach that achieves the benefits of regulation.

Commonwealth Government:

Costs: None

Benefits: Commonwealth legislation in areas such as Medicare rely on State and Territory registration systems to identify suitably trained practitioners and regulate standards of practice.

6. References

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APPENDIX 1: SUMMARY OF SUBMISSIONS
REVIEW OF MEDICAL PRACTICE ACT & NURSES ACT

19 January 1999

KEY

CATEGORY A: Submissions from Registration Boards, unions, professional associations, peak bodies, Specialist Colleges, educational institutions/student groups, Department.

CATEGORY B: Submissions from health service provider organisations, including health care networks, hospitals, health centres etc.

CATEGORY C: Submissions from nursing organisations.

CATEGORY D: Submissions on specific issues: Overseas trained doctors, chiropractic advertising.

CATEGORY E: Submissions from individual nurses.

Key to topics: See sections of Discussion Paper titled: "Review of Nurses Act 1993 and Medical Practice Act 1994" October 1998.

TABLE 1: Category A, B, C submissions, Contact persons, NCP restrictions, Victorian Model.

No.	Organisation	Contact Person	Registration restrictions?	Advertising restriction?	Intern Training controls?	Victorian model provisions?
A1	Medical Practitioners Board	Mr John Smith, Registrar	Yes	Yes	Yes	Yes
A2	Nurses Board of Victoria	Ms Leanne Raven, Chief Executive	Yes	No for nurses	-	Yes
A3	Chiropractors Registration Board	Mr Norman Brockley, Registrar	-	No	-	-
A4	Optometrists Registration Board	Mr J.G.Barkla Registrar	Yes	Yes	-	Yes
A5	Osteopaths Registration Board	Mr J.G.Barkla Registrar	Yes	Yes	-	Yes
A6	Pharmacy Board of Victoria	Mr Stephen Marty Registrar	Yes	strengthen	Yes	Yes
A7	Physiotherapists Registration Board	Mr J.G.Barkla Registrar	Yes	Yes	-	Yes
A8	AMA Vic Branch	Dr E Robyn Mason	Yes	strengthen	Yes	Yes
A9	ANF	Ms Belinda Morieson Secretary	Yes	Yes	-	pract. Protectn.
A10	HSUA	Mr Rob Elliott National Secretary	Yes	-	-	-
A11	HACSU	Mr David Stephens	-	-	-	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
A12	Aust Dental Association Vic.	Mr Gerard D Condon, President	Yes	Yes	Yes	
A13	Pharmaceutical Society of Australia	Mr Roger P. James CEO	Yes	Yes	Yes	-
A14	Aust. Podiatry Assn (Vic)	Ms Gail Mulcair Executive Officer	-	Yes	-	Yes
A15	Royal Australasian College of Surgeons	R C Bennett Executive Director for Surgical Affairs	-	strengthen	-	-
A16	Royal Aust & NZ College of Psychiatrists (Vic)	Dr John Buchanan Hon. Secretary	Yes	Yes	-	-
A17	Aust College of Dermatologists (Vic)	Dr Douglas Gin, Chair Victorian Faculty	-	strengthen	-	-
A18	APESMA	Chas Collison Executive Officer	Yes	-	-	-
A19	Private Hospitals Association	Ms Michelle Green Executive Director	Yes + PCAs	Unprof. Conduct	-	-
A20	General Practice Divisions Victoria	Dr Bill Newton CEO, GPD-V	-	-	-	-
A21	LaTrobe University (Nursing)	Ms Rhonda Nay Prof. Gerontic Nursing	Yes	Code of Conduct	-	Yes

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
A22	University of Melbourne (Nursing)	Prof. Judith Parker Head, School of Postgraduate Nursing	Yes	Yes	-	-
A23	Victoria University (Nursing)	Ms Gabrielle Koutoukidis, Nursing Coordinatory Cert. IV	Yes	-	-	-
A24	Swinburne University of Technology	Ms Joan Creber, *Coordinator Certificate* IV in Health (Nursing)	Yes	Yes NPs	-	-
A25		Mr Alistair Lloyd	Yes	strengthen+nurses	Yes	Yes
A26	Monash Uni. Med. UG Society	Ms Geraldine Buckingham, President Pre-clinical MUMUS	-	-	-	-
A27	Australian Plaintiff Lawyers Association	Mr Simon McGregor Nat. Policy Manager	Yes	-	-	-
A28	Howie & Maher Barristers & Solicitors	Ms Felicity Broughton	-	-	-	-
A29	Health Services Commissioner	Ms Beth Wilson	Yes	strengthen	Yes	Yes
A30	Pharmaceutical Health & Rational Use of Medicines Committee (PHARM)	Prof.Helen Baker Chair	Yes	-	-	-
A31	DHS - Mental Health	Mr Andrew Stripp, Assistant Director	Yes	false/misleading only	-	-
A32	DHS – Aged Care	Mr Alan Hall, Assistant Director	Yes + others	Yes	-	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
A33	Royal Australasian College of Medical Administrators	Mr Stephen Krul, Registrar	Yes	Yes	Yes	-
A34	Royal Australian College of Obstetricns & Gynaecologists	Mr Michael Rasmussen Chair, Vic State C'ttee	Yes	AMA view	Yes	Yes
A35	Chiropractors Assn of Vic.	Mr Norman Brockley Executive Director	-	No	-	protect practice
A36	Pharmacy Guild of Australia		Yes	Strengthen	Yes	Yes
A37	National Association of Nursing Homes and Private Hospitals Inc.	Mr Adrian de Jonk	further review	No	-	stream- line
A38	DHS - Disability Services	Mr Andrejs Zamurs	No for PCAs etc	-	-	-
A39	Dept of Justice	FN Lovass Acting Director		-	-	-
A40	Royal Australian College of Obstetricians and Gynaecologists	Mr M. Rasmussen Chairman, Victorian State Committee	Yes	AMA view	Yes	Yes

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
B1	The Australian Council of Healthcare Standards	Dr Denis Smith Chief Executive	Yes	Yes	Yes	Don't know
B2	Victorian Healthcare Association Ltd	Mr John Popper Managing Director	Yes	Yes	Yes*	Yes*
B3	Aged Care Victoria Inc.	Mr Peter Bunworth Chief Executive	Yes	No for NBV	-	-
B4	Victorian Insitute of Forensic Mental Health	Ms Karlyn Chettleburgh	Yes + PCAs	-	-	-
B5	Aust. College of Road Safety	Kerry Smith Executive Officer	-	-	-	-
B6	Freemasons Hospital	Ms Ros Pearson Director of Nursing	Yes + PCAs	Code of Conduct	-	-
B7	Mildura Private Hospital	Ms Trudie Chant Director of Nursing	Yes	-	-	-
B8	Health Care of Australia Mayne Nickless	Ms Alyson Sparkes Director of Nursing	Yes, Div 1 And nurse practitioners	-	-	-
B9	Health Care United P/L (Private General Practices)	Dr Henry Pinskier	Yes	Yes	-	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
B10	Austin & Repat. Med. Centre	Division 2 Nurse Exec.	Yes	-	-	-
B11	Monash Medical Centre Southern Health Care Network	Ms Marguerite Abbott Nurse Program Director	Yes+ others	-	-	-
B12	Southern Health Care Network	Ms Elizabeth Kennedy Corporate Counsel	Yes +PCAs	FTAct & TP Act	Yes	Yes*
B13	Southern Health Care Network, Mental Health Program	Ms Kim Sykes Clinical Program Director (Nursing)	Yes	-	-	-
B14	Royal Childrens Hospital	Dr Robert Henning Staff Specialist Intensive Care	-	-	-	-
B15	Bairnsdale Regional Health Service	Ms Lorraine Broad Director of Nursing & Community Services	Yes	retain	-	yes, reduce delays
B16	Barwon Health The Geelong Hospital	Ms Valerie Zielinski	Yes + carers	No	-	-
B17	Bellarine Peninsula Community Health Service	Mr Rob Jane, Health Services Manager	Yes + PCAs	Yes + nurses	-	-
B18	Colac Community Health Service	Ms Elizabeth Eadie DON & Inpatient Serv's	Yes + PCAs	Yes + nurses	-	Yes
B19	Far East Gippsland Health & Support Service	Division 2 Nurses	Yes + others	Yes + nurses	-	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
B20	Hepburn Health Service	Ms Alice Reed Assoc. D.O.N.	Yes + others	-	-	-
B21	Kerang & District Hospital	M. J. Kendrick D.O.N.	Yes	-	-	-
B22	Maffra District Hospital	Mrs E.J. Thomson Nursing Coordinator	Yes	-	-	-
B23	Western District Health Service	Ms Janet Kelsh Director of Nursing	Yes	-	-	-
B24	Warburton Hospital	Dr John C Watts Director Med. Services	-	-	-	-
B25	Wimmera Health Care Group	Miss Wendy Lewis D.O.N. Services	Yes	-	-	-
B26	Doncaster & Templestowe Nursing Home & Day Centre	Ms Karen Blaszak Director of Nursing	Yes	-	-	-
B27	Good Shepherd Aged Services	Mrs P. M. Adam CEO/DON	Yes	no for nurses	-	-
B28	Royal District Nursing Service	Ms Beverley Armstrong D.O.N., Deputy CEO.	Yes	Yes for nurses	-	-
B29	Council of Nursing Home Directors	Ms Mandy Christie President	Yes & Div 2	-	-	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
B30	North Western Health	Mr Michael Standford	Yes	Yes	Yes	-
B31	The Alfred	Dr Michael K Walsh Chief Executive	Yes	Yes	Yes	-
B32	Dr Chris Steinfort	Dr Chris Steinfort	Yes	Yes	Yes	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
C1	Aust. Nursing Council	Ms Marilyn Gendek EO	Yes	Codes	-	CPE?
C2	Royal College of Nursing	Ms Elizabeth Percival Executive Director	Yes+ assistnt	g'lines	-	Yes + unreg wkers
C3	Ministerial Advisory Committee on Nursing	Mrs Philippa de Voil Chair	Yes + PCAs	prof. conduct	-	Yes
C4	Aust. College of Midwives Inc. (Vic)	Ms Julie Collette Hon. President	register MWs	No - nurses	-	Nurses & MWs
C5	Maternity Coalition	Dr K. Lane	MW on Board	-	-	recogn. Mwives
C6	Aust. Council of Community Nursing Services Inc.	Ms Jane Reilly Secretary	Yes	Yes - NPs	-	Yes
C7	Aust. & NZ College of Mental Health Nurses Inc.	Ms Ann Benson Victorian President	reg Div3 -1	-	-	restrict titles
C8	Aust. College of Nurse Management	Mrs Ann Turnbull President	Yes+ reg PCAs	No - nurses & MPs	Yes	Yes
C9	Assn of Professional Nurses Agents Inc.	Miss Dorothy Frost President	Yes +PCAs	-	-	-

No.	Organisation	Contact Person	Registration restrictions?	Advertising restrictions?	Intern Training Controls?	Victorian model provisions
C10	Victorian Perioperative Nurses' Group	Mr Jorge Acevedo-Rodriguez Chairman	Yes	-	-	-
C11	Enrolled Nurse Special Interest Group Melbourne (ANF)	Ms N. Birnie President	Yes	-	-	-
C12	Peninsular Nurses in Aged Care	Ms Robin Fuller President	Yes	-	-	-
C13	Cann Valley Bush Nursing Centre Inc.	Ms A. Mary Filmer	extend scope	-	-	-
C14	Barwon Community Nurses Network	Mr Rob Jane, Convenor	Yes	Yes nurses	-	-
C15	Healthstra Employment Clinical Nurse Specialists	Ms Margaret Nuttall Manager	Yes	-	-	-
C16	Freemasons Hospital	Senior Nursing Staff	Yes+ PCWs	Code only	-	-

TABLE 2: Categories A, B, C, Sections 4.1.1 to 4.1.6 of Discussion Paper - Registration Board Powers and Functions

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
A1	Medical Practitioners Board	-	NSW model	-	No	Yes	Yes
A2	Nurses Board of Victoria	training for Div 2 & amend DPCS.	NSW model & Olympics	-	-	Yes	No
A3	Chiropractors Registration Board	-	-	-	-	Yes	-
A4	Optometrists Registration Board	-	-	-	-	-	Yes
A5	Osteopaths Registration Board	-	-	-	-	-	-
A6	Pharmacy Board of Victoria	Medication admin training of Div 2	NSW model	Yes	-	Yes	Yes
A7	Physiotherapists Registration Board	-	Football physios	-	-	Yes	Yes
A8	AMA Victorian Branch	-	NSW model	No	No	No	Yes
A9	ANF	Agrees with Nurses Board	Yes	Protect title NSW model	-	Yes	-
A10	HSUA	No***	-	-	-	-	-
A11	HACSU	-	-	-	-	-	-
A12	Australian Dental Association (Vic)	-	uniformity NSW model		No	-	Yes

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
A13	Pharmaceutical Society of Australia	yes, review med. administration	Yes	will await Taskforce	supports AMA view	MP Board set standards	only overseas Drs
A14	Aust. Podiatry Assn (Vic)	-	-	-	-	-	-
A15	Royal Australasian College of Surgeons	-	NSW model	-	No	-	Yes
A16	Royal Aust & NZ College of Psychiatrists (Vic)	-	Mx NSW model	-	No	-	Yes
A17	Australian College of Dermatologists (Vic)	-	-	-	-	-	-
A18	APESMA	training req'd	-	-	-	-	-
A19	Private Hospitals Association	standard training	Yes	protect title	-	-	Yes
A20	General Practice Divisions Victoria	-	-	Wait till NP Proj	-	-	-
A21	La Trobe University (Nursing)	training + bridging	Yes	similar to Midwives	-	Yes	Yes MP Act
A22	University of Melbourne (Nursing)	Restrict medicatn admin.	-	-	-	-	-
A23	Victoria University (Nursing)	amend DPCS + training	-	-	-	-	-
A24	Swinburne University of Technology	train Div 2, restrict PCAs	-	protect status	-	Yes	-
A25	Mr Alistair Lloyd	train Div 2	-	yes prescribing rights eg optoms	-	-	Yes
A26	Monash Uni. Medical Undergrad. Society	-	-	-	-	-	Yes

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
A27	Australian Plaintiff Lawyers Association	-	-	-	-	-	-
A28	Howie & Maher Barristers & Solicitors	-	-	-	-	-	-
A29	Health Services Commissioner	retain restrictions, review CRUs	Yes, see Mental Health Act	Protect title	Yes	Yes	Yes+ nurses
A30	Pharmaceutical Health & Rational Use of Medicines Committee (PHARM)	Div 1 supervision of med'n admin.	-	-	-	-	-
A31	DHS - Mental Health	Dosett admin OK	NSW model + nurses	endorse regn certificates	No	-	No
A32	DHS - Aged Care	train Div 2 & review supervisn	NSW model + nurses	Protect title later	No	-	No
A33	Royal Australasian College of Medical Administrators	regulate other categories	national registration	protect title	review regn procedures	Yes	Yes
A34	Royal Australian College of Obstetricians & Gynaecologists	-	-	wishes to contribute	No	-	Yes
A35	Chiropractors Assn of Vic.	Protect practice	-	-	-	-	Yes
A36	Pharmacy Guild of Australia	Train Div 2	-	No prescribing	-	Yes	-
A37	National Association of Nursing Homes and Private Hospitals						
A38	Disbility Services DHS	No extension to Div 2 regn	-	-	-	-	-

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
B1	The Australian Council of Healthcare Standards	-	-	-	-	-	-
B2	Victorian Hospitals Association	-	telemedicine	-	Yes	Yes	Yes
B3	Aged Care Victoria Inc.	Amend re med. administration	-	-	-	-	-
B4	Victorian Insitute of Forensic Mental Health	Medication admin train Div 2	-	-	-	-	nurses - no
B5	Aust. College of Road Safety	-	NSW model	-	-	-	-
B6	Freemasons Hospital	train Div 2	Yes	Protect title	-	-	Yes nurses
B7	Mildura Private Hospital	training in wkplc	-	-	-	-	-
B8	Health Care of Australia	dereg Div. 2	Yes - waive fees	Regulate 2 divs	-	-	-
B9	Health Care United P/L	-	-	-	-	-	-
B10	Austin & Repatriation Medical Centre	train Div 2	-	-	-	-	-
B11	Monash Medical Centre Southern Health Care Network	train Div 2 same HSWs	-	Yes & medication admin	-	-	-
B12	Southern Health Care Network	train Div 2 - acute, all forms	Yes	Yes	No	Yes	No
B13	Southern Health Care Network, Mental Health Program	better mental health training	-	-	-	-	-

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
B14	Royal Childrens Hospital	-	NSW model - nurses & MPs	-	-	-	-
B15	Bairnsdale Regional Health Service	restrict med. admin	Fed jurisdiction	-	Yes	protect public	Yes
B16	Barwon Health The Geelong Hospital	train Div 2 articule to Div 1	-	-	-	-	-
B17	Bellarine Peninsula Community Health Service	train Div 2 + regulate others	National reg. body	regulate position	-	-	No
B18	Colac Community Health Service	train Div 2 & amend DPCS	Yes	regulate	-	-	-
B19	Far East Gippsland Health & Support Service	-	-	-	-	-	-
B20	Hepburn Health Service	UG & PG train	-	-	-	-	-
B21	Kerang & District Hospital	train Div 2	-	-	-	-	-
B22	Maffra District Hospital	-	-	-	-	-	-
B23	Western District Health Service	not educ. prepared	-	-	-	-	-
B24	Warburton Hospital	-	-	-	-	-	-
B25	Wimmera Health Care Group	train Div 2	-	-	-	-	-
B26	Doncaster & Templestowe Nursing Home & Day Centre	retain Regn	-	-	-	-	-

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
B27	Good Shepherd Aged Services	Train Div 2	-	-	-	-	-
B28	Royal District Nursing Service	Train Div 2	-	Yes	-	-	-
B29	Council of Nursing Home Directors	-	-	-	-	-	-

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
C1	Aust. Nursing Council	train Div 2 +restrict unreg.	Olympics,tele-medicine--> nat.regn	amend legn.	Nat.regn	Yes	No - nurses
C2	Royal College of Nursing	train Div 2 + amend DPCS	-	protect title	-	-	-
C3	Ministerial Advisory Committee on Nursing	train Div 2 + amend DPCS	-	-	-	-	-
C4	Aust. College of Midwives Inc. (Vic)	reg midwives separately	nat.regn	-	-	-	-
C5	Maternity Coalition	recogn. Mwives	-	-	-	-	-
C6	Aust. Council of Community Nursing Services Inc.	train Div 2, reg PCWs	NSW model Nat. Regn.	protect title see NSW model	-	-	-
C7	Aust. & NZ College of Mental Health Nurses Inc.	train Div 2, protect Div3 titles	-	-	-	-	-
C8	Aust. College of Nurse Management	train Div 2	Yes, nat. regn.	uniform standard	No	-	No
C9	Assn of Professional Nurses Agents Inc.	train & reg. PCAs	-	-	-	-	-
C10	Victorian Perioperative Nurses' Group	train Div 2 regulate others	-	-	-	-	-
C11	Enrolled Nurse Special Interest Group Melbourne (ANF)	train Div 2 & amend DPCS Act	-	-	-	-	-
C12	Peninsular Nurses in Aged Care	retain Div 2	-	-	-	-	-

No.	Organisation	4.1.1 Regulate Divisions	4.1.2 Emergencies	4.1.3 Nurse practnrs	4.1.4 Over-seas Drs	4.1.5 TCM	4.1.6 Reg. Students
C13	Cann Valley Bush Nursing Centre Inc.	Extend scope practice	-	-	-	-	-
C14	Barwon Community Nurses Network	train Div 2& regulate rest	nat. registration	-	-	-	No
C15	Healthstra Employment Clinical Nurse Specialists	train Div 2	-	-	-	-	-
C16	Freemasons Hospital Senior Nursing Staff	train Div 2	Yes	protect title	-	-	Yes

TABLE 3: Category A, B, C Submissions, Sections 4.2.1 to 4.2.8 of Discussion Paper - Complaints and Disciplinary Functions

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
A1	Medical Practitioners Board	Yes	Yes	Yes	Yes	Optn 4	Yes	S.40 NSW	Crt of A or S.Crt
A2	Nurses Board of Victoria	Yes	Yes	Not req'd	Not opposed	No	Not opposed	Not req'd	VCAT OK
A3	Chiropractors Registration Board	(not applicable)	Yes	Yes	-	-	-	-	-
A4	Optometrists Registration Board	(not applicable)	Yes	Yes	Yes	Yes Optn 4	Yes	S.40 NSW	Optom exp. SCt
A5	Osteopaths Registration Board	(not applicable)	Yes	Yes	Yes	Yes Optn 4	Yes	S.40 NSW	Osteo exp.SCt
A6	Pharmacy Board of Victoria	qualified	Yes	Yes	Yes	NZ option	Yes	Yes	VCAT, on law only
A7	Physiotherapists Registration Board	-	Yes	Yes	Yes	Yes Optn 4	Yes	S.40 NSW	VCAT
A8	AMA Vic Branch	Yes	Yes	Yes	Yes	NZ option	Yes	Yes	S.Ct pts law only
A9	ANF	-	Yes	qualified	define 'serious'***	register agencies	Yes	-	VCAT rehearing
A10	HSUA	-	-	-	-	-	Yes	-	-
A11	HACSU	-	-	-	-	-	-	-	-
A12	Aust. Dental Assn Vic.	Yes	Yes	Yes	***	Yes***	Yes	Yes	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
A13	Pharmaceutical Society of Australia	Yes	Yes	cautious support	Yes	Yes*	Yes	Yes	S.Crt
A14	Aust. Podiatry Assn (Vic)	-	-	-	-	Yes	-	-	-
A15	Royal Australasian College of Surgeons	-	-	-	-	-	Yes	-	expert.
A16	Royal Aust & NZ College of Psychiatrists	Yes	Yes	Yes	-	Yes	Yes	Yes	S.Crt
A17	Australian College of Dermatologists (Vic)	-	Yes	-	-	Health Ins. Act	-	-	-
A18	APESMA	-	-	-	-	-	-	-	-
A19	Private Hospitals Association	-	-	-	Yes	Yes	Yes	Yes	-
A20	General Practice Divisions Victoria	-	-	-	-	-	-	-	-
A21	La Trobe University (Nursing)	-	Yes	fairness?	Yes, on certificate	No	Yes	Yes	-
A22	University of Melbourne (Nursing)	-	-	-	-	-	-	-	-
A23	Victoria University (Nursing)	-	-	-	-	-	-	-	-
A24	Swinburne University of Technology	-	-	-	-	-	Yes	-	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
A25	Mr Alistair Lloyd	Pharmacy Inspectors	Yes	Yes	Yes	Yes license owners	Yes	Yes	pts of law
A26	Monash Uni. Med. Undergrad. Society	-	-	-	-	-	-	-	-
A27	Australian Plaintiff Lawyers Association	-	-	-	-	-	-	-	-
A28	Howie & Maher Barristers & Solicitors	-	-	-	-	-	-	Yes	-
A29	Health Services Commissioner	Yes	Yes	Yes	Yes	Yes register owners	Yes	Yes	S.Crt quest of law only
A30	PHARM	-	-	-	-	-	-	-	-
A31	DHS - Mental Health	Yes	Yes	Yes	Yes	Yes NZ option	Yes	Yes	VCAT
A32	DHS - Aged Care	Yes	Yes	Yes	Yes	Yes NZ option	Yes	Yes	VCAT
A33	Royal Australasian College of Med Admins.	-	Yes	-	Yes	Option 4	Yes	-	-
A34	Royal Aust. College of Obstetricns & Gynae'gist	-	-	-	Yes	-	Yes	-	-
A35	Chiropractors Association of Victoria	-	-	-	-	-	-	-	-
A36	Pharmacy Guild of Australia	Yes	Yes	Yes	Yes	Only medical owners	Yes	Yes	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
B1	The Australian Council of Healthcare Standards	-	-	-	-	-	-	-	-
B2	Victorian Hospitals Association	current provisions OK	Yes	Yes	Yes	No	Discretionary	Yes	Unable to comment
B3	Aged Care Victoria Inc.	-	No objection	-	Yes	No for NBV	-	-	-
B4	Victorian Insitute of Forensic Mental Health	-	-	-	Yes	No? - current licences OK	-	-	-
B5	Aust. College of Road Safety	-	-	-	-	-	-	-	-
B6	Freemasons Hospital	-	-	-	-	Yes	-	-	-
B7	Mildura Private Hospital	-	-	-	-	-	-	-	-
B8	Health Care of Australia	-	-	-	-	register nurse agencies	-	-	-
B9	Health Care United P/L	-	-	-	-	reg lay owners	-	-	-
B10	Austin & Repatriation Medical Centre	-	-	-	-	-	-	-	-
B11	Monash Medical Centre Southern Health Care Network	Yes	Yes	Yes	Yes	Yes	Yes	No- waste of resources	VCAT
B12	Southern Health Care Network	-	Yes	-	-	Yes	-	-	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
B13	Southern Health Care Network, Mental Health Program	-	-	-	-	-	-	-	-
B14	Royal Childrens Hospital	-	-	-	-	-	-	-	-
B15	Bairnsdale Regional Health Service	-	Yes	Yes	Yes	Yes	Yes	Yes	-
B16	Barwon Health The Geelong Hospital	-	-	-	-	-	-	-	-
B17	Bellarine Peninsula C'ity Health Service	-	Yes - 5 yrs experience	-	Yes	-	Yes	-	-
B18	Colac Community Health Service	-	Yes - 5 yrs experience	Yes	Yes	Option 4	Yes	Yes	-
B19	Far East Gippsland Health & Support Service	-	-	-	-	-	-	-	-
B20	Hepburn Health Service	-	-	-	-	-	-	-	-
B21	Kerang & District Hospital	-	-	-	-	-	-	-	-
B22	Maffra District Hospital	-	-	-	-	-	-	-	-
B23	Western District Health Service	-	-	-	-	-	-	-	-
B24	Warburton Hospital	-	-	-	-	-	-	-	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
B25	Wimmera Health Care Group	-	-	-	-	-	-	-	-
B26	Doncaster & Templestowe Nursing Home & Day Centre	-	-	-	-	-	-	Yes	-
B27	Good Shepherd Aged Services	-	Yes	-	Yes	No NBV - Cwlth legn	-	-	-
B28	Royal District Nursing Service	-	Yes	-	-	-	-	-	-
B29	Council of Nursing Home Directors	-	-	-	-	-	-	-	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
C1	Aust. Nursing Council	-	-	-	nat. consistency	-	-	-	-
C2	Royal College of Nursing	-	Yes	Yes	Yes	Yes	Yes	Yes	-
C3	Ministerial Advisory Committee on Nursing	discretionary?	Yes	not req'd	Yes	Yes Option 4	Yes	Yes	-
C4	Aust. College of Midwives Inc. (Vic)	Yes	Yes	Yes	Yes	No	Yes	Yes	-
C5	Maternity Coalition	-	-	-	-	-	-	-	-
C6	Aust. Council of Community Nursing Services Inc.	-	Yes 5 yrs in health	-	-	-	-	-	-
C7	Aust. & NZ College of Mental Health Nurses Inc.	-	-	-	-	-	-	-	-
C8	Aust. College of Nurse Management	status quo	Yes	status quo	-	status quo	-	-	-
C9	Assn of Professional Nurses Agents Inc.	-	-	-	-	register agencies	-	-	-
C10	Victorian Perioperative Nurses' Group	-	-	-	-	-	-	-	-
C11	Enrolled Nurse Special Interest Group Melbourne (ANF)	-	-	-	-	-	-	-	-

No.	Organisation	4.2.1 Warrants	4.2.2 Legal Panel	4.2.3 Disclosure	4.2.4 Defn. unprof.	4.2.5 Lay owners	4.2.6 Suppn Order	4.2.7 Lapse Reg.	4.2.8 Appeals
C12	Peninsular Nurses in Aged Care	-	-	-	-	-	-	-	-
C13	Cann Valley Bush Nursing Centre Inc.	-	-	-	-	-	-	-	-
C14	Barwon Community Nurses Network	-	Yes 5 yrs health exp.	-	Yes	-	Yes	-	-
C15	Healthstra Employment Clinical Nurse Specialists	-	-	Yes	-	-	-	Yes	-
C16	Freemasons Hospital Senior Nursing Staff	-	-	-	-	Yes	Yes	-	-

TABLE 4: Category A, B, C Submissions, Sections 4.3 - 4.4 of Discussion Paper: Other Registration Board Powers and Section 5

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
A1	Medical Practitioners Board	No	Yes	Yes	No	Yes - SA.	-	No	-	1-19
A2	Nurses Board of Victoria	Yes	-	Not req'd	Not req'd	Not opposed	Yes	Not req'd	Yes	oppose 10,11,18
A3	Chiropractors Registration Board	-	-	-	Yes	-	-	-	-	5,11,12 ,15,19.
A4	Optometrists Registration Board	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	-
A5	Osteopaths Registration Board	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	-
A6	Pharmacy Board of Victoria	Yes	-	Yes	Yes	Yes	Yes 2yrs	Yes	Yes	1-12, 14-19
A7	Physiotherapists Registration Board	Yes	-	Yes		No	Yes	Yes	Yes	-
A8	AMA Vic Branch	No	Yr 1 only	No	No	Yes	No	Yes		1-17 yes
A9	ANF	-	-	-	Yes	over $20,000	Govt funded	-	No. S34 fine	
A10	HSUA	-	-	-	-	-	-	-	-	-
A11	HACSU	-	-	-	-	-	-	-	-	-
A12	Aust. Dental Association Vic.	***	-	No	Yes*	No	Yes	-	-	-
A13	Pharmaceutical Society of Australia	Yes	-	Yes	Yes	Yes	Yes	Uniform	-	1-19 yes

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
A14	Aust. Podiatry Association (Vic)	-	-	-	No	-	-	-	-	-
A15	Royal Australasian College of Surgeons	-	-	-	No	No	-	-	-	-
A16	Royal Aust. & NZ College of Psychiatrists	Yes Mx	VMPF	Verdicts only	Mx No	Yes	Yes	-	-	1-17, 19 yes
A17	Australian College of Dermatologists (Vic)	-	-	-	Yes	Yes	-	-	-	1-19 yes
A18	APESMA	-	-	-	-	-	-	-	-	-
A19	Private Hospitals Association	Yes	-	-	Yes	Yes	Yes	-	-	-
A20	General Practice Divisions Victoria	-	-	-	-	-	-	-	-	-
A21	La Trobe University (Nursing)	Yes nurses	-	discuss more	No nurses	-	nat. study	-	Yes	-
A22	University of Melbourne (Nursing)	-	-	-	-	-	-	-	-	-
A23	Victoria University (Nursing)	Yes nurses	-	-	options	-	ongoing CPE	-	-	-
A24	Swinburne University of Technology	-	-	-	-	-	employer responsib.	-	-	-
A25	Mr Alistair Lloyd	Yes	-	Yes	Yes	Yes	Yes 2 yrs	Yes	1,3,yes	234689 10,11, 121418
A26	Monash University Medical Undergrad. Society	-	-	-	-	-	-	-	-	-

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
A27	Australian Plaintiff Lawyers Association	-	-	-	Yes	-	-	-	-	-
A28	Howie & Maher Barristers & Solicitors	-	-	Yes	Yes	-	-	-	-	-
A29	Health Services Commissioner	Yes	Yes	No	Yes	No	No	Yes	Yes	No to 9
A30	PHARM	-	-	-	-	-	-	-	-	-
A31	DHS - Mental Health	Yes	-	Verdicts	Yes	Yes	Yes	Yes	Yes	1-7,9, 12-15, 18,19
A32	DHS - Aged Care	Yes	-	Yes	Yes	Yes	Yes + MP	Yes	Yes	1-7,9, 10,12-15,18, 19
A33	Royal Australasian College of Medical Administrators	Yes	expand ITAC	voluntary	already req'd	-	-	-	-	-
A34	Royal Australian College of Obstetricns & Gynaecologists	-	retain tng length	-	Yes	$20,000 too low	other means	-	-	18 yes
A35	Chiropractors Association of Australia	-	-	-	No	-	-	-	-	-
A36	Pharmacy Guild of Australia	Yes	-	Yes	Yes	-	-	-	Yes	Yes

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
B1	The Australian Council of *Healthcare Standards*	Yes	Interim *council*	Condit'nal	Yes	Yes	assess *c'petence*	-	-	-
B2	Victorian Hospitals Association	Yes	-	Not req'd	Not req'd	Not opposed	Yes	Not req'd	Yes	oppose 10,11,18
B3	Aged Care Victoria Inc.	-	-	-	No?	-	Cont'd Ed req'mts	-	Yes	-
B4	Victorian Insitute of Forensic Mental Health	-	review nurses	-	No	No	Yes	-	suspens t'limit	-
B5	Aust. College of Road Safety	-	-	-	-	-	-	-	-	-
B6	Freemasons Hospital	-	-	-	Yes - both	Yes	Yes	-	Yes	-
B7	Mildura Private Hospital	-	-	-	-	-	-	-	-	-
B8	Health Care of Australia	-	-	-	-	-	-	-	-	-
B9	Health Care United P/L	-	-	-	Yes - both	-	-	-	-	-
B10	Austin & Repatriation Medical Centre	-	-	-	-	-	-	-	-	-
B11	Monash Medical Centre Southern Health Care Network	-	-	-	-	-	-	-	-	-
B12	Southern Health Care Network	discretion	Yes	-	Yes - both	Yes	Yes	Yes	Yes	13 - yes

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
B13	Southern Health Care Network, Mental Health Program	-	-	-	No	No	-	-	-	-
B14	Royal Childrens Hospital	-	-	-	-	-	-	-	-	-
B15	Bairnsdale Regional Health Service	Yes	-	Yes	-	Yes	Yes	-	-	-
B16	Barwon Health - Geelong Hospital	-	-	-	-	-	-	-	-	-
B17	Bellarine Peninsula Community Health Service	-	-	-	-	-	recognise backgrnd	-	qual'd Yes	-
B18	Colac Community Health Service	Yes	-	-	private pract.	-	comp'tenc not time	-	Yes	-
B19	Far East Gippsland Health & Support Service	-	-	-	-	-	-	-	-	-
B20	Hepburn Health Service	-	-	-	-	-	-	-	-	-
B21	Kerang & District Hospital	-	-	-	-	-	-	-	-	-
B22	Maffra District Hospital	-	-	-	-	-	-	-	-	-
B23	Western District Health Service	-	-	-	-	-	Yes + CPE	-	Yes	-
B24	Warburton Hospital	-	-	-	-	-	-	-	-	18 &19 with care
B25	Wimmera Health Care Group	-	-	-	Yes	-	-	-	-	-

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
B26	Doncaster & Templestowe Nursing Home & Day Centre	-	-	-	-	-	-	-	-	-
B27	Good Shepherd Aged Services	-	-	-	No NBV	-	Yes + CPE	-	Yes	-
B28	Royal District Nursing Service	-	-	-	Yes	-	assessmt	-	No	-
B29	Council of Nursing Home Directors	-	-	-	-	-	-	-	-	-

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
C1	Aust. Nursing Council	national approach	-	health lab.force	-	-	ongoing competnc	-	Yes	-
C2	Royal College of Nursing	Yes	-	Yes	No-nurses	qualifying reports	no guarantee	-	Yes	-
C3	Ministerial Advisory Committee on Nursing	Yes	-	-	Private practice	Yes	redefine + CPE	-	Yes	-
C4	Aust. College of Midwives Inc. (Vic)	ACMW	-	Some	No	Yes	No	Yes	Yes	-
C5	Maternity Coalition	ACMW	-	-	No	-	-	-	-	-
C6	Aust. Council of Community Nursing Services Inc.	-	-	-	split	-	anomalies	-	1- no	-
C7	Aust. & NZ College of Mental Health Nurses Inc.	-	-	-	-	-	-	-	-	-
C8	Aust. College of Nurse Management	-	-	-	self emp	-	-	-	Yes	-
C9	Assn of Professional Nurses Agents Inc.	-	-	-	-	-	-	-	-	-
C10	Victorian Perioperative Nurses' Group	-	-	-	-	-	-	-	-	-
C11	Enrolled Nurse Special Interest Group Melbourne (ANF)	-	-	-	-	-	-	-	Yes	-
C12	Peninsular Nurses in Aged Care	-	-	-	-	-	-	-	-	-

No.	Organisations	4.3.1 Guidelns	4.3.2 PG training	4.3.3Regn Renew	4.3.4 P.I.I.	4.3.5 Settlemts	4.3.6 Recency	4.4 Proceds.	NBV Recs	MPB Recs.
C13	Cann Valley Bush Nursing Centre Inc.	-	-	-	-	-	-	-	-	-
C14	Barwon Community Nurses Network	-	-	-	split	-	anomalies	-	1- No	-
C15	Healthstra Employment Clinical Nurse Specialists	-	-	-	-	-	too vague remove	-	-	-
C16	Senior Nursing Staff, Freemasons Hospital	-	-	-	Yes MPs NPs	Yes	Yes MPs & Nurses	-	-	-

TABLE 5: Categories D and E - Specific Issue Submissions

No.	Name	Organisation and Address	Issue 1	Issue 2
D1	Dr Eugene P Kalnin, President	Aust. Drs Trained Overseas Association	Overseas trained doctors registration	
D2	Dr Boris Mezhov & Mr C.W. Barfoot	Overseas trained doctor	Overseas trained doctors registration	
D3	Dr Michael Galak	Overseas trained doctor	Overseas trained doctors registration	
D4	Dr B.M. DSiddiqui	Overseas trained doctor	Overseas trained doctors registration	
D5	Dr Gerard Christian Chiropractor	Derrimut Road Chiropractic Centre		Use of testimonials in Chiropractic Health News
D6	Mr Brett Warden	Chiropractor		Use of testimonials in Chiropractic Health News
D7	Dr Graham Le Lievre	Le Lievre Chiropractic Practice Company P/L		Use of testimonials in Chiropractic Health News
D8	Mary Gillett MP/ Dr Henry Chen	Member for Werribee		Use of testimonials in Chiropractic Health News
D9	Mr Richard W Edmonds	Edmonds Chiropractic Clinic		Use of testimonials in Chiropractic Health News
D10	Dr Nick Hodgson	Chiropractor, Ocean Grove and Drysdale Chiropractic Clinics.		Use of testimonials
D11	Mr John H. Wilson	Chiropractic Health News		Use of testimonials in Chiropractic Health News