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Health Legislation Amendment (Podiatric Surgery and Other Matters) Bill 2004

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I N F O R M A T I O N A N D R E S E A R C H S E R V I C E S

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No. 137 2003–04

Health Legislation Amendment (Podiatric Surgery and
Other Matters) Bill 2004

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21 May 2004

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Health Legislation Amendment (Podiatric Surgery and Other Matters) Bill 2004

Date Introduced: 1 April 2004

House: House of Representatives

Portfolio: Health and Ageing

Commencement: The different parts of Schedule 1 of the Bill have various commencement dates, as indicated under 'Main provisions', below.

Purpose

This Bill is an omnibus bill which proposes various, unrelated amendments to legislation within the Health and Ageing portfolio:

- Schedule 1, Part 1 provides for amendments to the *Health Insurance Act 1973* to enable private health insurance funds to provide benefits for the hospital treatment costs associated with foot surgery performed on admitted patients by accredited podiatrists
- Schedule 1, Part 2 provides for amendments to paragraphs within the *Health Insurance Act 1973* which relate to the provision by private hospitals of Hospital Casemix Protocol data to the Department of Health and Ageing
- Schedule 1, Part 3 provides for amendments to provisions within the *National Health Act 1953* which govern the Pharmaceutical Benefits Scheme (PBS), to provide for the continuing supply of pharmaceutical benefits in the event of the death of a PBS-approved pharmacist
- Schedule 1, Part 4 provides for minor amendments to the *Health and Other Services (Compensation) Act 1995* and the *Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Act 2003* to correct drafting errors.

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Background

Schedule 1—Part 1—Amendments relating to payment of benefits for hospital treatment associated with podiatric surgery

This part of the Bill proposes amendments to the *Health Insurance Act 1973* to enable private health insurance funds to provide benefits from their hospital tables for hospital accommodation and nursing costs associated with foot surgery performed in hospitals by registered podiatric surgeons.

Podiatry and the podiatric workforce in Australia

Podiatry (also known as chiropody) deals ‘with the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs’.¹ Podiatrists treat a range of conditions, including those which result from ‘bone and joint disorders such as arthritis and soft-tissue and muscular pathologies, as well as neurological and circulatory disease’.² Podiatric surgery is a branch of podiatry, specialising in the treatment of feet and lower limb conditions which warrant surgical intervention.³

The majority of work podiatrists do involves older patients experiencing difficulty with mobility as a result of injury, structural problems, or the effects of chronic diseases. Diabetes, for example, if not adequately controlled, can damage nerves and cause problems with blood supply to the feet. Foot conditions often develop with age; subsequently, demand for podiatrists is likely to grow as the Australian population ages.⁴

According to the Podiatry Labour Force Survey conducted by the Australian Institute of Health and Welfare (AIHW) in 1999, there are over 2200 registered podiatrists in Australia. The podiatry workforce has grown rapidly in recent years: it increased by 42.7 per cent over the 8-year period 1991 to 1999.⁵ By contrast, there are only a small number of podiatric surgeons—approximately 25—in Australia.⁶ The majority of podiatrists counted in the AIHW’s 1999 survey (74.5 per cent) worked in the private sector.⁷

The practice of podiatry in Australia is regulated by state and territory legislation.⁸ To become a podiatrist, a practitioner must complete a recognised undergraduate degree, and be registered to practise with a state or territory registration board.⁹ Podiatric surgeons are podiatrists who have undergone additional postgraduate training, and who have successfully completed the requirements for admission to the Australasian College of Podiatric Surgeons (ACPS).¹⁰ They are not required to have medical degrees.

Under state and territory legislation, podiatrists are licensed to perform a limited range of foot surgery, including soft tissue procedures such as toe nail removal.¹¹ The vast majority of these kinds of procedures are performed in podiatrists’ rooms, community health centres, and some hospitals (though generally in out-patient facilities). Podiatric surgeons can perform more complex surgical procedures, including deep tissue surgery and some

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bone surgery (such as hammer toe corrections).¹² Many of these procedures are also performed in podiatrists' rooms, but as they may require the use of general anaesthetic, they tend to be performed in hospitals.

Podiatric surgeons have been performing foot surgery in Australia since the early 1970s. However, podiatrists and podiatric surgeons are not recognised as medical practitioners (they are classified as allied health professionals). Consequently, the number of hospitals—both private and public—in which podiatric surgeons are able to perform surgical operations is very limited.¹³

As the section below on podiatry and health insurance discusses, podiatrists' and podiatric surgeons' services do not attract Medicare rebates, and are only eligible for private health insurance coverage in some circumstances. Subsequently, much of the foot surgery that could be performed by podiatric surgeons is performed by orthopaedic surgeons instead. However, there is evidence to suggest that the treatment outcomes of foot conditions treated by podiatrists and podiatric surgeons are as good, and in many cases better, than when the same conditions are treated by orthopaedic surgeons and other registered physicians.

Therefore, there seem to be good reasons, from a public health perspective alone, for expanding the availability of podiatric surgeons' services within the Australian health system.¹⁴ Such an expansion would bring Australia into line with treatment patterns elsewhere: in the USA, for example, podiatrists perform almost two-thirds of all major (orthopaedic) foot surgery (compared with only 10–15 per cent in Australia). In the UK, podiatric surgeons operate widely within the National Health Service, the UK's public health system (whereas they tend to operate almost exclusively in the private sector in Australia).¹⁵

Podiatry and health insurance: current arrangements

Until this year, podiatry and the services of other allied health care professionals have not been eligible for any rebates under the Medicare program—Australia's publicly funded health insurance scheme. According to the Explanatory Memorandum circulated with this Bill:

Extending Medicare benefits coverage to a wider range of allied health care providers (which includes podiatrists) has been considered on other occasions and each time it has been decided that it is not possible to extend these arrangements given the economic climate. This is still the case.¹⁶

However, the revised Medicare Plus package negotiated earlier this year between independent senators and the government has resulted in Medicare benefits being made available, in some circumstances, for services provided by allied health care professionals (including podiatrists) for the first time.¹⁷ However, because the new benefits will only apply to consultations with allied health professionals for services delivered 'for and on

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behalf of a GP', it is unlikely they will extend to surgical procedures performed by podiatric surgeons.

Private health insurance which includes ancillary (or extras) cover provides cover for non-hospital services which are generally not covered by Medicare. Out of hospital services provided by podiatrists and podiatric surgeons (as well as those provided by other allied health professionals such as dentists, chiropractors, home nurses, physiotherapists, and occupational therapists) are covered by most private health insurance policies with ancillary cover.

As mentioned above, foot surgery performed by podiatric surgeons often needs to take place in hospital because of the need for general anaesthetic. However, *in-hospital* foot surgery performed by podiatric surgeons is not covered by private health insurance. Under the Health Insurance Act, private health insurance benefits for in-hospital treatment are only payable for treatment performed by providers of 'professional attention', which includes medical practitioners, nurses with obstetric qualifications (midwives), and dental practitioners. Podiatric surgeons are not recognised as medical practitioners, and therefore are not included as providers of 'professional attention' under the Health Insurance Act. In its 2003 assessment of governments' progress in implementing the National Competition Policy and related reforms, the National Competition Council found that this arrangement restricts competition between medical practitioners and 'substitute health care providers', such as podiatrists.¹⁸

Patients with ancillary health cover may be eligible for limited benefits towards the cost of podiatric surgery performed in a hospital, but the patient usually has to pay the full cost of hospital accommodation and nursing care. In other words, people who choose to have foot surgery performed by podiatric surgeons in hospital are likely to be liable for all of the out-of-pocket costs associated with the surgery. The amendments proposed by this Bill will make it possible for private health insurance companies to pay benefits towards the cost of hospital accommodation and nursing care for podiatric surgery performed on admitted patients.¹⁹

The extension of private health insurance benefits to foot surgery performed by podiatric surgeons raises some issues about public patients' equity of access to equivalent kinds of treatment (since podiatric surgeons practice in only a very small number of public hospitals). However, as noted above, orthopaedic surgeons also perform the kinds of surgery in which podiatric surgeons specialise.²⁰ Public patients therefore have access to the same type of treatment which this Bill will enable private health insurance funds to provide cover for. It is also important to bear in mind that the amendments proposed by this Bill will not alter existing foot surgery practice, and in the short term, are unlikely to significantly alter treatment patterns. That is, the Bill, if passed, will not change the kinds of procedures podiatric surgeons currently are and are not able to perform, or where they are able to perform them. Rather, it will simply allow private health insurance funds to pay benefits for accommodation and nursing costs associated with procedures which are already being performed.

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Position of significant interest groups

Both the Australasian Podiatry Council, the peak body representing podiatrists' in Australia, and the Australasian College of Podiatric Surgeons, the body which develops, implements and monitors guidelines for the practice of podiatric surgery in Australia, fully support the amendments proposed by the Bill.

According to the Explanatory Memorandum accompanying the Bill, 'certain medical groups' have expressed concern about the safety and quality of surgical procedures performed by podiatric surgeons, and the level of training podiatric surgeons receive. However, these concerns are rarely expressed publicly. Further, there is little, if any, clinical evidence which supports these concerns. In any case, as noted above, the amendments proposed by this Bill will not alter existing foot surgery practice, but simply make it possible for private health insurance funds to provide some benefits for in hospital foot surgery performed by podiatric surgeons.

Schedule 1—Part 2—Amendments relating to provision of Hospital Casemix Protocol Data

This part of the Bill proposes amendments to provisions within the Health Insurance Act and the National Health Act which govern the collection of data about the activities and outputs of private hospitals in Australia. The proposed amendments will update the existing legislative provisions to reflect current practice for the collection of this data and are likely to be uncontroversial.

What is Hospital Casemix Protocol Data?

Data on Australia's hospitals and the health system is collected and published by a number of agencies.²¹ Detailed and comprehensive data collection is important for monitoring the effectiveness of Australia's hospitals and health care system, as well as for planning for the future.

The Hospital Casemix Protocol Data Collection—which is managed by the Department of Health and Ageing—was established to monitor the deregulation of the private health industry, following the 1995 Private Health Insurance Reform legislation.²² The Hospital Casemix Protocol refers to the arrangement whereby private hospitals provide the Department of Health and Ageing with a series of patient de-identified casemix data. Patient de-identified data means data which does not identify individual patients. 'Casemix' data refers to data which incorporates both the number and types of patients treated, and the mix of diagnoses, treatments, procedures, and so on provided to patients. Casemix data is a way of measuring, monitoring and comparing hospitals' output and activities.²³ Private hospitals are required to supply this data under Section 23EA of the Health Insurance Act:

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For the purposes of this Act and the National Health Act 1953, a declared private hospital must provide data specified in the Hospital Casemix Protocol:

- (a) in a patient identifiable state, to a registered private health insurance organization which has an applicable benefits agreement with the patient;
- (b) in a patient de-identified state to a data bureau established for the purpose of receiving and disseminating such data.

The Department releases the Hospital Casemix Protocol data annually to all private hospitals, registered health funds, and various external stakeholders. The data can be used to analyse trends, compare variations in charges between different hospitals, and examine the effects of clinical and patient demographics.²⁴

The collection of Hospital Casemix Protocol data

The Private Hospitals Data Bureau was established in 1997, following the 1995 amendments to the Health Insurance Act. Between 1997 and 2002, the Department funded an external agency to perform the functions of the Private Hospitals Data Bureau, and to collect Hospital Casemix Protocol data from private hospitals on the Department's behalf. However, during this time, both private hospitals and the Department itself experienced problems with access to the data, and with the completeness of the data collection. Subsequently, since January 2003, the Department has managed the Private Hospitals Data Bureau internally. Since the Department took over the management of the Private Hospitals Data Bureau, it has worked with the private hospital industry to improve the accessibility of the data, the completeness of the data collection, and to streamline the process of collecting the data itself.

The first amendment proposed by this part of the Bill removes the reference in Section 23EA of the Health Insurance Act to the 'data bureau', and replaces it with 'the Department'. This will not change existing practice, but rather reflects the current arrangements.

The second amendment proposed by this part of the Bill inserts a new subsection in the National Health Act, which will require day hospitals—that is, facilities in which the procedures performed do not require an overnight hospital stay—to provide both private health insurance funds and the Department with the same Hospital Casemix Protocol data that private hospitals are obliged to provide under the Health Insurance Act.

This amendment, if passed, may lead to a change in existing practices, in that day hospitals have hitherto not been required to provide health insurance funds or the Department—or the Private Hospitals Data Bureau, when it was in existence—with Hospital Casemix Protocol data (though many day hospitals may already provide this information, even if they are not under any legal obligation to do so). Imposing this requirement on day hospitals will improve the comprehensiveness of the Hospital Casemix

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Protocol Data Collection, and therefore the ability of the Department and other stakeholders to monitor day hospitals' output and activity, as well as that of the private hospital sector as a whole.

The Department will be required to observe both the *Privacy Act 1988*, and the secrecy provisions in section 135A of the National Health Act and section 130 of the Health Insurance Act in using the data collected under the provisions proposed by this part of the Bill.

Position of significant interest groups

The Australian Private Hospitals Association, the peak body for private hospitals in Australia, supports both amendments proposed by this part of the Bill. The Australasian Day Surgery Association supports the amendments pertaining to the provision of Hospital Casemix Protocol data by day hospitals.

Schedule 1—Part 3—Amendments relating to the Pharmaceutical Benefits Scheme

This part of the Bill proposes a series of amendments to provisions within the *National Health Act 1953* which relate to the continuing supply of pharmaceutical benefits in the event of the death of a pharmacist who was approved to supply pharmaceutical benefits at or from particular premises.

The proposed amendments seek to remove deficiencies in the existing provisions. While the volume of amendments proposed by this part is substantial compared to Parts 1 and 2 of Schedule 1 of the Bill, most of the amendments are technical in nature and do not represent new policy. Therefore, this part of the Bill is likely to be uncontroversial.

Existing provisions for the supply of pharmaceutical benefits following the death of a pharmacist

The Pharmaceutical Benefits Scheme (PBS) is the publicly funded scheme for the subsidisation of medicines which exists under the National Health Act. State and territory legislation regulates the registration of pharmacists and the practice of pharmacy (that is, the actual dispensing and compounding of medicines). Under the National Health Act, however, to supply PBS medicines, a pharmacy must be approved by the Commonwealth Department of Health (on the recommendation of the Australian Community Pharmacy Authority).²⁵

State and territory legislation also provides for legal personal representatives of deceased pharmacists' estates to continue deceased pharmacists' businesses, as long as the actual practice of pharmacy in the business is conducted by a registered pharmacist.²⁶ There are provisions in section 90 of the National Health Act for legal representatives of deceased pharmacists to apply for approval to supply PBS medicines at or from the premises at

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which the deceased pharmacist was approved by the Commonwealth to supply pharmaceutical benefits—that is, to continue the deceased pharmacists’ business with respect to the supply of PBS medicines. However, according to the Bill’s Explanatory Memorandum, this provision has been found to be deficient in a number of respects. For example:

In some cases, the time period involved in obtaining an approval under section 90 is lengthy. This is particularly so if it is only viable for a legal representative to apply for approval after probate or letters of administration are granted.

In some instances, the legal personal representative requests an Act of Grace payment be made to the estate of the deceased approved pharmacist in relation to pharmaceutical benefits supplied during the period following the death of the approved pharmacist and before the granting of a section 90 approval. In some cases the amount claimed is large, and the ongoing viability of a pharmacy has been jeopardised by having to carry this financial burden.²⁷

The proposed amendments are intended to enable a person who is, or is likely to become, an executor or administrator of the estate of a deceased pharmacist, to apply for permission to supply pharmaceutical benefits (for PBS purposes) at or from the particular premises at which the deceased pharmacist was approved. The amendments are also intended to clarify that in cases where a beneficiary of a deceased approved pharmacist is not a pharmacist, s/he ‘may only apply under section 90 for approval to supply pharmaceutical benefits in circumstances where he or she has acquired the deceased approved pharmacists’ interest in the pharmacy’.²⁸

The amendments do *not* give legal representatives of deceased approved pharmacists the right to practice pharmacy—as noted above, state and territory legislation regulates the registration of pharmacists and requires that, in the event of the death of a pharmacist, the actual practice of pharmacy must be carried out by a registered pharmacist. Nothing in section 90 of the National Health Act (or the amendments proposed by this part of the Bill) ‘authorizes the Secretary [of the Department of Health and Ageing] to grant approval to a pharmacist in respect of premises at which that pharmacist is not permitted, under the law of the State or Territory in which the premises are situated, to carry on business’.²⁹ Rather, the amendments simply seek to improve the process by which a person who acquires a deceased pharmacist’s interest in a pharmacy can apply for reimbursement, under the PBS, for PBS medicines dispensed.

Schedule 1—Part 4—Miscellaneous amendments of other health legislation

This part of the Bill proposes minor amendments to other legislation within the health portfolio to correct minor errors. The proposed amendments are discussed under ‘Main Provisions’, below.

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Main Provisions

Schedule 1—Part 1—Amendments relating to payment of benefits for hospital treatment associated with podiatric surgery

The following items all relate to the *Health Insurance Act 1973*.

Item 1 inserts a definition of ‘accredited podiatrist’ to subsection 3(1) of the Act.

Item 3 expands the Act’s definition of ‘professional attention’ (which currently includes treatment performed by or under the supervision of medical practitioners, nurses with obstetric qualifications and dental practitioners) to include podiatric treatment performed by an accredited podiatrist.

Item 4 inserts two new subsections (3AAA and 3AAB) which provide for the accreditation of podiatrists by the Minister for the purposes of the Act, and for appeal to the Administrative Appeals Tribunal for review of the Minister’s decision in this regard.

Schedule 1, Part 1 commences on a date to be fixed by Proclamation, or if this does not occur within 6 months of Royal Assent, on the first day after the end of that period.

Schedule 1—Part 2—Amendments relating to provision of Hospital Casemix Protocol Data

Item 5 and **Item 6** amend paragraphs of the *Health Insurance Act 1973* and the *National Health Act 1953* pertaining to the collection of Hospital Casemix Protocol data, for the purposes described in the ‘Background’ section, above.

Schedule 1, Part 2 commences when the Act receives Royal Assent.

Schedule 1—Part 3—Amendments relating to the Pharmaceutical Benefits Scheme

The following items all relate to the *National Health Act 1953*.

Item 7 and **Item 8** repeal existing definitions of ‘pharmacist’ and ‘approved pharmacist’ in subsections 4(1) and 84(1) respectively, and replace them with revised definitions.

Item 10 inserts new subsections (90(3AC) and 90(3AD)) defining when an interest in a deceased pharmacists’ business has been acquired for the purposes of the Act.

Item 12 prevents beneficiaries of deceased approved pharmacists, who are not pharmacists themselves, from applying for approval to supply pharmaceutical benefits under section 90 unless they have acquired the deceased approved pharmacist’s interest in the pharmacy.

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Item 13 inserts a new section 91 which sets out the process for granting approval to the executor or administrator of the estate of a deceased approved pharmacist to supply pharmaceutical benefits at or from the premises from which the deceased pharmacist had been approved. **Item 14** provides for appeal to the Administrative Appeals Tribunal for review of decisions in this regard.

Schedule 1, Part 3 commences on a date to be fixed by Proclamation, or if this does not occur within 6 months of Royal Assent, on the first day after the end of that period.

Schedule 1—Part 4—Miscellaneous amendments of other health legislation

Items 15 to 18 propose minor amendments to the *Health and Other Services (Compensation) Act 1995* and the *Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Act 2003* to amend typographical and other drafting errors.

The provisions in Schedule 1, Part 4 commence immediately after the time specified for the commencement of the relevant sections and items in the Acts this part of the Bill amends.

Concluding Comments

None of the proposed amendments contained in this Bill are significant in terms of numbers of persons affected or in terms of government expenditure or savings—the financial impact of the Bill is negligible.

With the possible exception of Schedule 1, Part 1, the proposed amendments do not represent any change to existing policy or practice, but rather, will streamline, improve, and/or codify existing arrangements, and are therefore likely to be uncontroversial. As noted above, the amendments proposed by Schedule 1, Part 1 (pertaining to podiatric surgery) raise some questions about public patients' ability to access the kinds of treatment performed by podiatric surgeons, since orthopaedic surgeons appear to have a monopoly on foot surgery performed in public hospitals at present. However, the issue of whether or not podiatric surgeons' services should be made more widely available in the public hospital system is beyond the scope of this Bill.

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Endnotes

- 1 Australasian Podiatry Council (APODC) website: see: <http://www.apodc.com.au/Podiatry%20in%20Australia/scope.htm> (accessed 9 May 2004).
- 2 *ibid.*
- 3 Australasian College of Podiatric Surgeons (ACPS) website: see: <http://www.acps.edu.au/surgery.html> (accessed 9 May 2004).
- 4 Australian Institute of Health and Welfare (AIHW), *Podiatry Labour Force 1999*, National Health Labour Force Series, Number 23, AIHW, Canberra, 2002, p. 1.
- 5 *ibid.*, pp. 5–7.
- 6 Explanatory Memorandum, p. 3.
- 7 AIHW, *op. cit.*, pp.5–7
- 8 The Northern Territory, which does not regulate the practice of podiatry, is the exception to this rule.
- 9 APODC website: see <http://www.apodc.com.au/Education/Education.htm> (accessed 11 May 2004).
- 10 ACPS website: see <http://www.acps.edu.au/surgery.html> (accessed 11 May 2004). The ACPS is the national organisation responsible for the ‘development, implementation and monitoring of guidelines for the practice of podiatric surgery in Australia’. The ACPS was established in 1976 and is affiliated with the Australasian Podiatry Council.
- 11 A podiatrists’ license to practice generally includes a license to use local anaesthesia where appropriate. In some states, some podiatrists are also licensed to prescribe and supply S4 (prescription only) drugs.
- 12 ACPS website: see <http://www.acps.edu.au/surgery.html> (accessed 11 May 2004).
- 13 Less than 10 out of approx. 540 private hospitals have granted podiatric surgeons admitting rights—Explanatory Memorandum (p.3). The number of *public* hospitals in which podiatric surgeons have admitting rights is believed to be even less.
- 14 It should be pointed out, however, that the Explanatory Memorandum (at p.6) notes that ‘some medical groups’ have expressed concern about the levels of training podiatric surgeons receive, and whether they are amply qualified to perform non-superficial procedures. Bennett and Patterson note that objections by the medical profession to surgical podiatry have also focused on podiatrists’ ‘pharmacological knowledge and pre-operative and post-operative care’ (Bennett and Patterson 1997, *op. cit.*, p.48). However, as noted above, there is little, if any, clinical evidence which supports these concerns. Orthopaedic surgeons have also expressed concerns ‘about encroachment into their own specialty by surgical podiatrists and the resulting economic competition’ (Bennett and Patterson 1997, *op. cit.*, p. 48).
- 15 Bennett and Patterson 1997, *op. cit.*, pp.47–48.
- 16 Explanatory Memorandum, p. 3.

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- 17 The measures contained in the Medicare Plus package will only apply to services being provided by an allied health provider, 'for and on behalf of a GP', for patients with a chronic condition and complex care needs who are being managed under a multidisciplinary care plan through the Enhanced Primary Care (EPC) program—see the Department of Health and Ageing's Medicare Plus website: http://www.health.gov.au/medicareplus/update_march_04/glance04.htm#section4 (accessed 11 May 2004). Doctors' groups have expressed concern that few doctors will take up the allied health measures contained in Medicare Plus because of burdensome administrative arrangements associated with the measures—see Adam Cresswell and George Liondis, 'Red tape hinders Medicare plan: Concern about allied health/EPC link', *Australian Doctor*, 19 March 2004, pp. 1–2.
- 18 National Competition Council, *Assessment of governments' progress in implementing the National Competition Policy and related reforms: Volume two – Legislation review and reform*, AusInfo, Canberra, 2003, p. 98.
- 19 The amendments proposed by the Bill will not make it possible for health funds to pay benefits towards the cost of podiatric surgeons' or associated anaesthetists' fees, because podiatric surgery will still not be covered by the Medicare Benefits Schedule (MBS).
- 20 Though as also noted above, there is some evidence to suggest that the treatment outcomes from procedures performed by podiatric surgeons are as good, and in some cases better, than those performed by orthopaedic surgeons. However, the issue of expanding the availability of podiatric surgeons' services in public hospitals is beyond the scope of this Bill.
- 21 These include the Department of Health and Ageing, the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, various state and territory health agencies, and various non-government stakeholders and interest groups.
- 22 Department of Health and Ageing, Australian Hospital Information, Performance Information Program website: see <http://www.health.gov.au/casemix/hcp/hcpmain1.htm> (accessed 11 May 2004).
- 23 *ibid.*, see: <http://www.health.gov.au/casemix/glossary1.htm> (accessed 11 May 2004).
- 24 *ibid.*, see: <http://www.health.gov.au/casemix/hcp/hcpmain1.htm> (accessed 11 May 2004).
- 25 Warwick J. Wilkinson, *National Competition Policy Review of Pharmacy—Preliminary Report*, Council of Australian Governments, Canberra, 1999, p. ii.
- 26 Explanatory Memorandum, p. 1, See: for example, the [Pharmacy Act 1964 \(NSW\)](#), sections 27 and 29.
- 27 *ibid.*
- 28 *ibid.*, p. 2.
- 29 *National Health Act 1953*, section 90(4).

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