CHAPTER 2

DESIGN OF THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR DOCTORS AND OTHER HEALTH WORKERS

INTRODUCTION

Changes to the proposed Scheme arising from national consultation

2.1 As noted in Chapter 1, a national consultation on the national registration and accreditation scheme (NRAS/the Scheme) has been undertaken through the National Registration and Accreditation Implementation Project (NRAIP), as an integral part of the process of implementing the Scheme.

2.2 The Committee notes that a number of changes to the NRAS, as proposed in the NRAIP consultation papers, were contained in the exposure draft of the Health Practitioner Regulation National Law (Bill Bill). The Australian Health Workforce Ministerial Council (AHWMC) communiqué of 8 May 2009 acknowledged the participation of the health professions in the consultative processes, and outlined a number of changes to the Scheme as originally proposed. The changes included:

- ensuring that accreditation functions are independent of government;
- establishing both general and specialist registers for professions, as well as separate registers for nurses and midwives;
- requirements for continuing professional development in relation to annual renewal of registration;
- extension of the Scheme to three other professions from 1 July 2012 (Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners and medical radiation practitioners);
- a requirement that the larger jurisdictions each have at least one representative on the National Boards; and that the smaller jurisdictions between them have at least one representative
- a requirement that National Boards be required to consider applications for registration from practitioners seeking to work in a location or position that has been declared as an area of need
- adoption of the National Privacy Principles and privacy regime by the Scheme; and
- a number of changes to registration arrangements 'to improve the quality and safety of health services being delivered to the public', including:
    - mandatory reporting by practitioners of registrants who are placing the public at risk of harm;

- mandatory criminal history and identity checks for first-time registrants; and a power for National Boards to conduct ad hoc criminal history and identity checks;
- simplified complaints arrangements; and the ability of jurisdictions to employ either national or state/territory law as the legislative framework for investigations and prosecutions related to complaints; and
- registration of students in the health professions.[1]

2.3 The Committee notes that the changes outlined above addressed many of the concerns that had been raised in submissions to the inquiry and in the Committee's hearing on 7 May 2009 (which preceded the release of Bill B). Notwithstanding the issues discussed below, this point was generally acknowledged by submitters and witnesses. The Royal Australasian College of Surgeons (RACS), for example, commented that Bill B represented a 'considerable improvement on the initial design for…[NRAS]'.[2] Mr Ian Frank, Chief Executive Officer, Australian Medical Council (AMC), commented:

> The AMC would like to commend the members of the…[NRAS] team for their efforts in drawing together the complexities of health practitioner regulation in Australia into a single piece of legislation. The AMC notes that many of the issues raised in previous submissions…have been reflected in the exposure draft of bill B.[3]

2.4 The Australian Osteopathic Association (AOA) observed that Bill B showed 'clear signs that earlier concerns expressed by various professional groups…have been given careful consideration'. Further, it noted that the Australian Health Workforce Ministerial Council (AHWMC/the Ministerial Council) 'and those advising it have been at clear pains to accommodate concerns where that has been found possible'.[4]

ISSUES

2.5 The following issues were identified as being of concern to stakeholders generally.

Independence of accreditation

Directions on accreditation standards by Ministerial Council

2.6 The independence of accreditation processes under NRAS was perhaps the major issue raised throughout the inquiry. Submitters and witnesses generally

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1 Australian Health Workforce Ministerial Council, Communiqué, 8 May 2009, pp 1-5, available at http://www.nhwt.gov.au/natreg.asp.

2 *Submission 20a*, p. 1.

3 *Proof Committee Hansard*, 14 July 2009, p. 19.

4 *Submission 6c*, p. 1.

acknowledged that there had been significant improvements in this area, as reflected in Bill B. The Optometrists Association of Australia (OAA), for example, noted that the changes announced in the 8 May 2009 communiqué had 'largely removed governments from inappropriate involvements in the accreditation function'.[5]

2.7 In relation to outstanding concerns about the independence of accreditation processes, Dr Louise Morauta, Project Director, NRAIP, confirmed that these had been raised by a number of submissions to the national consultation, and would be considered by minsters in due course.[6]

2.8 A common view expressed by stakeholders was that the independence of accreditation processes was still potentially threatened by a power granted to the Ministerial Council to issue directions relating to accreditation standards. This power is set out in clause 10 of Bill B:

> (1) The Ministerial Council may give directions to the National Agency about the policies to be applied by the National Agency in exercising its functions under this Law.
>
> (2) The Ministerial Council may give directions to a National Board about the policies to be applied by the National Board in exercising its functions under this Law.
>
> (3) Without limiting subsections (1) and (2), a direction under this section may relate to:
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> …
>
> (d) a particular accreditation standard for a health profession.[7]

2.9 The power to give a direction in relation to a particular accreditation standard, as proposed in Bill B, is restricted to circumstances where the standard may have a negative effect on workforce supply:

> (4) …the Ministerial Council may give a National Board a direction under subsection (3)(d) only if, in the Council's opinion, the accreditation standard will have a substantive and negative impact on the recruitment or supply of health practitioners to the workforce.[8]

2.10 The position of the Australasian Podiatry Council (APodC) was broadly indicative of the professions' views. APodC submitted that that the power in clause 10(4) was fundamentally inconsistent with the object of the Scheme to ensure that health professionals are suitably qualified to ensure patient safety:

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5 *Submission 40a*, p. 2.

6 *Proof Committee Hansard*, 14 July 2009, p. 62.

7 Health Practitioner Regulation National Law, Exposure Draft, clause 10(1)-(3), p. 11, available at http://www.nhwt.gov.au/natreg.asp.

8 Health Practitioner Regulation National Law, Exposure Draft, clause 10(4), p. 11.

> The need to ensure appropriately qualified and competent health professionals and supply them in sufficient numbers across all of Australia are competing demands, however…first and foremost, those persons registered to work as health professionals must have the knowledge and experience to provide quality health care, for the benefit of patients and the health of the nation. APodC believes that this power of the Ministerial Council to amend accreditation standards runs contrary to this objective.[9]

2.11 APodC noted that the pursuit of workforce planning outcomes via the clause 10(4) power could therefore be at the expense of public health and safety:

> This power, if used, 'may change standards, which may prove incompatible with the objectives of protecting and improving public health and safety'.[10]

2.12 Similarly, Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association (ADA), observed:

> Provision of a directive that might compromise safety and quality yet meet an area of need demand would be inappropriate.[11]

2.13 Mr Frank pointed to the inherent tension between public safety and workforce planning issues in relation to accreditation:

> …there is a very fine balance between workforce supply and quality and safety issues. Unfortunately, if you look back in time then you will see that whenever workforce has become an issue quality and safety tends to sort of fall off the agenda a bit. There is a tension between those two. We do not have to look back very far in time to realise that recently in our near north this became a serious issue when existing established assessment processes were bypassed in the interests of supplying a workforce to a particular health service.[12]

2.14 In addition to these concerns, the Australian Psychological Society (APS) was concerned that the power could stifle the ongoing development of standards:

> …if the ministerial council has the ability to intervene to effectively veto proposed changes to standards in education and training, this may limit the accrediting body's power to stimulate change and reform in education programs, with the potential risk that the Australian programs of professional training and education may fail to keep pace with international benchmarks.[13]

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9 *Submission 77a*, p. 2.

10 *Proof Committee Hansard*, 13 July 2009, p. 2.

11 *Proof Committee Hansard*, 13 July 2009, p. 49..

12 *Proof Committee Hansard*, 14 July 2009, p. 21-22.

13 Professor Lyn Littlefield, Executive Director, *Proof Committee Hansard*, 13 July 2009, p. 29.

2.15 Submitters and witnesses emphasised that the proposed power 'clearly contradicts the intention of there being independence from government in accreditation' processes.[14] In particular, it was observed that any such decision could be made 'without involving discussion with the profession or the accreditation body':[15]

> …the arrangements as proposed leave open the possibility that policy will be set without any practitioner involvement at all. This is a radical departure from existing arrangements whereby Ministers can issue directions to public servants administering state and territory boards but cannot issue directions to board members on issues of policy.[16]

2.16 Further, the RACS submitted that, in practice, the power could potentially allow the Ministerial Council to intervene in nearly all cases:

> Technically, the "recruitment or supply of health practitioners to the workforce" is always an issue, so this clause could be invoked at any time.[17]

2.17 There was a variety of views amongst submitters and witnesses as to the appropriate response to clause 10(4), ranging from calls for its removal to suggestions for amendments to constrain and/or make more transparent any use of the power.

2.18 The ADA recommended that clause 10(4) be deleted so as to remove entirely the power of the Ministerial Council to give a direction in relation to an accreditation standard.

2.19 In the alternative, the ADA suggested that exercise of the power be wholly limited to cases involving a 'significant and negative impact upon ensuring health services are provided safely and are of appropriate quality'.[18] The Royal Australian College of General Practitioners (RACGP) also supported an amendment having the effect that 'it is the quality of health care and patient safety rather than issues of workforce upon which the Ministerial Council will intervene'.[19] Similarly, the APS submitted:

> …such a power should be limited to situations in which the standard in question might have a negative impact on the quality of training and practice or on safety in providing care to the public. That is enshrined in the bill as objectives and guiding principles of the scheme, which is clause 4(1). Under clause 4(1), if that was the reason for the ministerial council to

14 Australian Dental Association, *Submission 31a*, p. 7.

15 Dr Sue Whicker, Chief of Staff, APodC, *Proof Committee Hansard*, 13 July 2009, p. 11.

16 Royal Australasian College of Surgeons, *Submission 20a*, p. 1.

17 *Submission 20a*, p. 1.

18 *Submission 31a*, p. 8.

19 *Proof Committee Hansard*, 14 July 2009, p. 36.

> intrude into this, that is a legitimate reason, because it is protecting the public.[20]

2.20 Other groups felt that the power for the Ministerial Council to issue directions relating to accreditation standards in cases involving negative impacts on workforce supply was legitimate, but should be constrained either by public interest or safety considerations, or exceptional circumstances requirements. The OAA submitted:

> …the justification for the Ministerial Council being able to issue a policy direction to a Board in respect of an accreditation standard should be a public interest test as well as recruitment or supply of health practitioners to the workforce. Quality, best practice and safety should be considered as well as workforce shortage before issuing a policy direction in respect of a standard.[21]

2.21 The Committee of Presidents of Medical Colleges (CPMC) also called for the power to be constrained by reference to 'public interest' or 'safety and quality'.[22]

2.22 The RACS, while acknowledging that there 'may be some merit' in retaining the power, suggested:

> …[The words] 'in exceptional circumstances in the public interest' could be added [to the clause]…[so] that a greater degree of public interest must be determined and that it needs to be exceptional circumstances [before the power may be used].[23]

2.23 The RACGP felt that an even broader scope of operation for the power than just simply a public good test might, in conjunction with greater transparency, ensure that the exercise of the power was only done for proper purposes.[24]

2.24 Dr Andrew Pesce, President, Australian Medical Association (AMA), called for 'greater codification…of the circumstances in which the Ministerial Council will be able to use this power'.[25] The AMA submission outlined a comprehensive set of amendments and additional mechanisms to ensure greater certainty and accountability:

> A. provide more specific codification in the Bill of the parameters for how and when any Ministerial Council directions are made in relation to accreditation standards under clauses 10(3)(d) and 10(4), including:
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> 1. defining "substantive and negative impact" in subclause 10(4);

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20 Professor Lyn Littlefield, Executive Director, *Proof Committee Hansard*, 13 July 2009, p. 29.

21 *Submission 40a*, p. 2.

22 *Submission 15a*, p. 2.

23 Dr David Hillis, Chief Executive Officer, *Proof Committee Hansard*, 13 July 2009, p. 84.

24 *Proof Committee Hansard*, 14 July 2009, p. 38.

25 *Proof Committee Hansard*, 14 July 2009, p. 45.

2. requiring the Ministerial Council to apply a public interest test that considers, amongst other things, the potential impact on the quality and safety of patient care;

3. requiring the Ministerial Council to consult with the relevant Learned Medical College and faculties on best practice;

B. require that Ministerial Council decisions to issue the medical board a policy direction under clauses 10(3)(d) and 10(4) be unanimous;

C. provide for more transparency of policy directions made under clauses 10(3)(d) and 10(4) by:

1. requiring directions to set out:

i. the findings on material questions of fact;

ii. references to the evidence or other material on which those findings were based; and

iii. give the reasons for the decision to issue the policy direction;

2. requiring Ministerial Council directions to the medical board made under clauses 10(3)(d) and 10(4) to be provided in writing to peak medical organisations and Learned Medical College and faculties, and to be published on National Agency's website, within seven working days of the direction being issued;

D. provide additional accountability for Ministerial Council directions made under clauses 10(3)(d) and 10(4) through the inclusion of specific provisions for reviewing any such directions.[26]

2.25 A number of groups called for mandatory processes of review and reporting around the exercise of the clause 10 power. The ADA considered that such processes would be desirable if the power were to remain in the Scheme.[27] The RACGP called for the recommendations of health boards in relation to accreditation standards, and the reasons for any rejection of any standards, to be made public.[28]

2.26 In relation to publication issues, Dr Morauta noted that the directions of the ministerial council were required to be published. Further, if a direction or an accreditation standard was refused by a national board then an accrediting authority would have the right to publish its advice. The ministerial council would also be required to place its policy directions on the public record.[29]

2.27 The Committee accepts that misuse of the powers proposed is improbable—given that the maintenance of high professional standards is a cornerstone of the

26 *Submission 29b*, pp 3-4.

27 *Submission 31a*, p. 8.

28 *Proof Committee Hansard*, 14 July 2009, p. 36.

29 *Proof Committee Hansard*, 14 July 2009, p. 63

Australian health system and in the mutual interest of every stakeholder in that system. However, the Committee also believes that safeguards against such misuse could enhance confidence in the new national system.

Recommendation 1

2.28 The Committee recommends that the Australian Health Workforce Ministerial Council fully consider and evaluate the potential usefulness and feasibility of the proposed amendments to clauses 10(3) and 10(4) of the Health Practitioner Regulation National Law (Bill B), especially those proposed by the Australian Medical Association (AMA).

Appointment of external accreditation bodies by Ministerial Council

2.29 A number of groups expressed concern about the role of the Ministerial Council in the appointment of external accreditation bodies. Clause 60 of Bill B provides:

> (1) The Ministerial Council may appoint an entity, other than a committee established by a National Board, to exercise an accreditation function for a health profession under this Law.
>
> (2) Without limiting subsection (1), an entity that accredited courses for the purposes of registration in a health profession under a corresponding prior Act may be appointed to exercise an accreditation function for the profession under this Law.[30]

2.30 The OAA submitted that accreditation processes should in both appearance and practice remain free of government:

> …Ministerial Council alone should not appoint external accreditation authorities. Further consideration should be given to a more arms length process of appointing the external accreditation authorities which ensures they are and are seen to be independent of governments, professions and educators.[31]

2.31 The APS warned that the proposed arrangements carried a risk of politicisation of accreditation authorities:

> …the draft bill gives the ministerial council the power to appoint the accrediting entity. This power should be in the hands of the national board to protect the process of setting training standards from the influence of political concerns such as workforce issues and cost savings.
>
> As this bill is drafted, a ministerial council in the future may choose to appoint an accrediting agency which serves the government's political needs rather than the public's interests in quality of training and practice.[32]

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30 Health Practitioner Regulation National Law, Exposure Draft, p. 32.

31 *Submission 40a*, p. 2.

32 *Proof Committee Hansard*, 13 July 2009, p. 28.

2.32 The CPMC was also concerned that the current arrangements could mean that there remained potential for 'political interference in the accreditation process'.[33]

2.33 The OAA was particularly concerned that, beyond the transitional arrangements, there was no provision for how accreditation bodies would be appointed.[34] Mr John Beever, National Government Affairs Manager, advised:

> Specifically, we are concerned about the power for the ministerial council to appoint the accreditation agencies after the transition period. We find that difficult to reconcile with the notion of a truly independent authority. We would like to propose a number of improvements to the accreditation arrangements, with the major one probably being that we think there needs to be more work done on how accreditation authorities are appointed.[35]

2.34 The APS called for 'clarification' around the composition of accreditation bodies appointed by the Ministerial Council.[36] This approach was supported by the OAA, which wanted the 'composition of the accreditation authority to be specified', along the lines of current appointments processes. Mr Joe Chakman, Executive Director, explained:

> One method of providing that independence is the one that is currently used by most of the accreditation authorities where the actual composition of the authorities is specified in some way. Usually…there are nominees from education, from the professions, from the boards. So you have the three central pillars of the professions represented there and making the decisions on what standards and quality should be.[37]

2.35 Alternatively, the APS called for the power to appoint accreditation authorities to be devolved to the National Boards.[38] The RACS supported this approach:

> The College can see no good reason for the Ministerial Council to be involved in this process [of appointing accreditation entities], as Section 60 currently proposes…
>
> We do not support the involvement of the Ministerial Council in the appointment of accreditation authorities.[39]

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33 *Proof Committee Hansard*, 13 July 2009, p. 36.

34 *Proof Committee Hansard*, 13 July 2009, p. 17. The Committee understands that existing accreditation authorities will be retained in the transition to the Scheme on 1 July 2010.

35 *Proof Committee Hansard*, 13 July 2009, p. 16.

36 *Proof Committee Hansard*, 13 July 2009, p. 36.

37 *Proof Committee Hansard*, 13 July 2009, p. 16.

38 *Proof Committee Hansard*, 13 July 2009, p. 36.

39 *Submission 20a*, p. 2.

2.36 The AMA also called for the National Boards to exclusively appoint accreditation entities:

> …given that national boards can establish accreditation committees under clause 62, it would secure the independence of the accreditation process if the national boards, and not the Ministerial Council, were fully responsible for ongoing appointments of external accreditation entities. [40]

2.37 Further, the AMA sought an explicit guarantee that the AMC would continue, over the transition period and beyond, as the external accrediting body for the medical profession:

> The AMA…seeks a guarantee that the AMC will be the external accrediting body for the medical profession, and that it will have an ongoing role, beyond an initial three-year period, as the external accrediting body for medical education and training…We are concerned that the Ministerial Council may seek to influence accreditation processes by appointing, and presumably revoking appointments of, external accreditation entities under clause 60. The medical profession has a high regard for the operation and activity of the AMC. There is no reason why the AMC should not be appointed as the external accrediting body for a period substantially longer than three years. [41]

2.38 The CPMC recommended that the Ministerial Council be required to act on the recommendation of, or in consultation with, the National Boards in the appointment of accreditation entities.[42]

2.39 The AMC, however, felt that in practice, beyond the transitional phase, the appointment of accreditation bodies by the Ministerial Council would be adequately informed by the existing boards, and therefore would be unlikely to be open to unwarranted influences. Mr Frank explained:

> …if we read [clause] 290 under the transitional provisions, we see that in…that three-year [transitional] period the national board will undertake a review; and the national board will make recommendations to the ministerial council about assigning the functions beyond that three-year period. So we are comfortable with the way that mechanism, taken as a whole, will operate at this point.[43]

2.40 Further, Mr Frank observed that accreditation processes had historically been subject to ministerial direction, without adverse consequences, and that accreditation entities would need to continue to demonstrate and justify their effectiveness:

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40 *Submission 29b*, p. 4.

41 *Submission 29b*, p. 4.

42 *Submission 15a*, p. 4.

43 *Proof Committee Hansard*, 14 July 2009, p. 22.

> At any point in time governments…can make policy decisions and change direction and follow all sorts of different lines of development. But basically we have a robust, well-developed system. It is compliant with World Federation for Medical Education guidelines. It has very great stakeholder involvement and participation…[Along] with all the other health professions, [the AMC will continue to] make our case and demonstrate the effectiveness of our processes and the integrity of our processes, but that is something we have been faced with since we were first established...[44]

Other accreditation issues

Definition of 'accreditation standard'

2.41 The AMC felt that the definition of 'accreditation standard' contained in Bill B was 'too narrow'. Mr Frank advised that the definition should 'reflect learning and a continuous quality improvement of medical education'.[45]

2.42 Mr Frank commented:

> The concern we have got is that medical education is actually a lifelong process. What you really need to do is ensure that the accreditation standards are robust enough to ensure that there is a continuous educational process inculcated in the graduates.[46]

2.43 Mr Frank suggested that the definition should refer to the concept of 'continuous practice':

> I think that the standard needs to refer to continuous practice—not that a person is capable of practicing at the time of graduation but that they can continue to develop and evolve their processes—and that the systems that you build and the institutions that you look at have actually got elements built into them that can sustain that process; they would have elements of exposure to, say, innovation, research et cetera so that the trainees do come out with a focus on lifelong learning and not just simply a skills set that enables them to function on day 2 or day 3 of their entry into the workforce.[47]

2.44 The AMA submitted:

> The AMA asks that the draft Bill include the definition of accreditation standard provided by the existing national accreditation agencies for the health professions.[48]

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44 *Proof Committee Hansard,* 14 July 2009, p. 22

45 *Proof Committee Hansard,* 14 July 2009, p. 19.

46 *Proof Committee Hansard,* 14 July 2009, p. 28.

47 *Proof Committee Hansard,* 14 July 2009, p. 28.

48 *Submission 29b,* p. 5.

Conditional accreditation

2.45 The APS was concerned that the NRAS as proposed did not make provision for conditional accreditation. 'Conditional accreditation' allows an accrediting body to grant accreditation on condition that an entity satisfy specified requirements within a certain timeframe. This could be, for example, a requirement that an education or training body establish a specified teaching ratio within 12 months, to ensure an adequate staff- to-student ratio.[49] The capacity to grant conditional accreditation was desirable as it meant that a training program, for example, would not have to lose accreditation for failing to meet a single requirement.

2.46 Dr Morauta advised that this issue had been raised by 'several stakeholders' in the course of national consultations, and particularly in meetings with accreditation authorities.[50]

Composition of National Boards

2.47 Under the current form of Bill B it is proposed that National Boards will be comprised of nine people. A formula is contained in clause 45 which provides, inter alia:

> (1) A National Board is to consist of members appointed in writing by the Ministerial Council.
>
> (2) Members of a National Board are to be appointed as practitioner members or community members.
>
> (3) Subject to this section, the Ministerial Council may decide the size and composition of a National Board.
>
> (4) At least half, but not more than two-thirds, of the members of a National Board must be persons appointed as practitioner members.
>
> (5) The practitioner members of a National Board must consist of:
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> (a) at least one member from each large participating jurisdiction, and
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> (b) at least one member from a small participating jurisdiction.
>
> (6) At least 2 of the members of a National Board must be persons appointed as community members.
>
> (7) At least one of the members of a National Board must live in a regional or rural area.[51]

2.48 For the purposes of clause 45(5), the large participating jurisdictions are:

- Queensland;

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49 *Proof Committee Hansard*, 13 July 2009, p. 29.

50 *Proof Committee Hansard*, 14 July 2009, p. 65.

51 Health Practitioner Regulation National Law, Exposure Draft, p. 24.

- New South Wales;
- Victoria;
- South Australia; and
- Western Australia.

2.49 For the purposes of clause 45(5), rhe small participating jurisdictions are:

- Tasmania;
- Australian Capital Territory; and
- Northern Territory.

Representation of small jurisdictions

2.50 A number of professions indicated concern that the small participating jurisdictions would not be adequately represented on the National Boards.

2.51 The AMC, for example, submitted:

> We have some concerns that the composition of the national board, as set out in section 45, which allows all of the larger states but only one of the three smaller states to be involved in the national board, is probably a retrograde step.[52]

2.52 Mr Frank observed that historically the smaller jurisdictions tended to have circumstances that were quite different from those of the larger jurisdictions. It was therefore necessary that smaller jurisdictions were represented on the National Boards, to enable local knowledge of those conditions to be properly recognised through national forums:[53]

> Certainly our experience with input from the smaller states and territories in Australia in relation to things like area of need registration and the very heavy reliance on overseas-trained practitioners is that they have a unique set of circumstances and problems, particularly in relation to supervision, monitoring, setting of conditions et cetera.[54]

2.53 Dr Kay Sorimachi, Director, Policy and Regulatory Affairs, Pharmaceutical Society of Australia (PSA), advised :

> Because of…the importance of having representation of state and territory boards we believe that the national board must have a representative from every jurisdiction in order to accommodate any state-specific or territory-specific issues. Therefore, the current proposed composition whereby the

52 *Proof Committee Hansard*, 14 July 2009, p. 20.

53 *Proof Committee Hansard*, 14 July 2009, p. 24

54 *Proof Committee Hansard*, 14 July 2009, p. 20.

> smaller participating jurisdictions would be allowed only a combined nomination is not adequate for the pharmacy profession.[55]

2.54 The Australasian Conference of Chiropractic Registration Boards (ACCRB) was also concerned about the proposed representation of small jurisdictions, and called for additional members on its National Board:

> The Chiropractors Registration Boards strongly support a Chiropractors Registration Board of Australia with an additional two members to allow for representation from all Australian jurisdictions.[56]

2.55 The AMA submitted:

> We note that the membership of the national boards will comprise at least one member from the smaller participating jurisdictions. This may be an issue of concern for members of the health professions in those smaller jurisdictions who may consider their interests will not be adequately represented at the National level. Over time, there is a real risk that registration and complaints handling functions for registrants in smaller jurisdictions may be carried out outside the jurisdiction. There could be implications for patient safety if local issues are unable to be taken into account because there is no local knowledge.[57]

2.56 Dr Morauta advised that there was scope for individual representation of smaller jurisdictions in the Scheme as currently proposed:

> The size and composition of the board are determined from time to time by the ministerial council both under the existing act and under bill B. If ministers said that the board was going to be, say, 12, then it would be perfectly possible for the three smaller jurisdictions each to have a practitioner member on a particular occasion if ministers wished to do it that way.[58]

Composition of National Boards of particular professions

2.57 The Committee heard a variety of views on the preferred composition of the respective National Boards, largely reflecting individual characteristics of the professions.

Psychology

2.58 The APS commented that it did not believe the current formula's requirements for mandatory representation of jurisdictions would result in the best representation for the psychological profession:

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55 *Proof Committee Hansard,* 13 July 2009, p. 95.

56 *Submission 80a*, p. 5.

57 *Submission 29b*, p. 6.

58 *Proof Committee Hansard,* 14 July 2009, p. 64.

> [The proposed formula] means that the best people cannot go up because, for instance, we would have had two or three people in New South Wales, a couple in Victoria and, in some states…there was no-one we thought had the level of expertise of these other people. Our concern is the board will not have the best people on it because of the formula.[59]

2.59 APS was concerned with ensuring representation by people with relevant accreditation and registration experience, as well as non-health psychology, over and above concerns about ensuring state representation per se.[60] Accordingly, it proposed increasing the number of representatives on its National Board to 12:

> We put in a formula of 12, way back in one of our submissions. There could be eight of the profession and four community members. That eight would actually allow you to get two more really good people on the board who are perhaps not representative of a particular state. I understand what is behind it with the state health ministers wanting someone from each state. I understand the rationale, but I just think it is a great pity not to get the best people, particularly in the establishment phase.[61]

Dentistry

2.60 The ADA commented that the current formula for the composition of national boards would not allow for sufficient representation of the four types of practitioners that make up the dentistry profession as a whole: dentists, dental hygienists, dental prosthetists and dental therapists.

> We…have problems with the make up of the board, particularly given the special nature of dentistry…Given that [the profession has] more than one type of practitioner…we believe there should be more dentists on the board…We fully support all of the other professions being represented on the board.[62]

2.61 The ADA also called for a larger national board for dentistry to ensure that the four dentist professions could be represented for each jurisdiction. Dr Neil Hewson, President, advised:

> We think the board will have to be bigger because we do not think it is appropriate for the other professions not to be represented with one of each.[63]

2.62 Mr Robert Boyd-Boland, Chief Executive Officer, explained:

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59 *Proof Committee Hansard,* 13 July 2009, p. 38.

60 *Proof Committee Hansard,* 13 July 2009, p. 39.

61 Professor Lyn Littlefield, *Proof Committee Hansard,* 13 July 2009, p. 39.

62 Dr Neil Hewson, President, ADA, *Proof Committee Hansard,* 13 July 2009, p. 45.

63 *Proof Committee Hansard,* 13 July 2009, p. 48.

> [The Dental Board]…is going to be looking after four professions…The bill…[provides] that half to two-thirds—but no more than two-thirds—of the board will be professionals. We certainly think that, in view of the need for representation of four dental professionals, that needs to be adjusted accordingly to enable a group of, say, at least eight practitioners to be on the board and then the two community members.[64]

2.63 Accordingly, the ADA called for its National Board to be extended to include 'at least two additional dentists 'to ensure that the…[Board] can suitably carry out its functions including determining standards for all of dentistry.[65]

2.64 The ADA also called for the position of chair of the National Board to be a dentist. The ADA submission explained:

> The dentist is the team leader in the practice of dentistry and is the only practitioner with the knowledge and skills to practice all of dentistry. While dental hygienists, dental therapists and dental prosthetists have appropriate knowledge and skills for their limited areas of practice, these are confined to limited specific areas of dentistry.[66]

Osteopathic

2.65 The AOA submitted that the proposal for mandatory geographic representation on its National Board would result in 'the vast majority of osteopaths [effectively being prevented]…from nominating for the National Board', due to the fact that around 80 per cent of all practitioners were located in NSW and Victoria. Accordingly, the AOA called for the NRAS to contain provisions allowing the smaller professions to appoint alternatives when no suitably experienced or qualified practitioner is available from smaller jurisdictions.[67]

2.66 In respect of the composition of National Boards for particular professions, Dr Morauta noted:

> What it says, both in this bill and the one under which the current appointments are being made, which is the first act, is that the composition and mix of the board is as determined from time to time by the ministerial council. That has always been regarded as important, because if you had a new sub profession come up you might want to have a different sized board or a differently composed board. What this bill and the first act do is say that there are some rules around this. We have to have no more than two-thirds of practitioners—no less than half and no more than two-thirds. The chair must be a practitioner member. In this draft of the bill, the five large jurisdictions are guaranteed a member and the three smaller ones have to

64 *Proof Committee Hansard*, 13 July 2009, p. 48.

65 *Submission 31a*, p. 10.

66 *Submission 31a*, p. 10.

67 *Submission 6c*, p. 8.

> share. That is the minimum requirement. What happens is that ministers can certainly play with the size of the board on any occasion that they want. Or they might want various bits represented on it—dental is a good example, because it has prosthetists, hygienists and therapists in it. How many of those do you want on the board? Ministers can at any time decide what they want there. That is the flexibility in the current act, which enables them to decide. That is also in this draft bill.[68]

Mandatory reporting

2.67 Clauses 156 and 157 of Bill B introduce for health practitioners and employers requirements for the mandatory reporting of 'reportable conduct by health professionals. 'Reportable conduct' is defined as instances where a health practitioner has:

> (a) practised the health practitioner's profession while intoxicated by drugs or alcohol, or
>
> (b) engaged in sexual misconduct in connection with the practice of the health practitioner's profession, or
>
> (c) placed the public at risk of substantial harm in the health practitioner's practice of the profession because the health practitioner has an impairment, or
>
> (d) placed the public at risk of substantial harm because the health practitioner has practised the profession in a way that constitutes a departure from accepted professional standards.[69]

2.68 The Medical Indemnity Industry Association of Australia (MIIAA) was opposed to the proposed system of mandatory reporting, arguing that it would create a 'punitive atmosphere' and a 'culture of fear' among practitioners that would inhibit the open disclosure of otherwise reportable conduct.[70] Dr Sara Bird, Medico-legal Manager; and Advisory Services Coordinator, MDA National Insurance, explained:

> …mandatory reporting…[is] a retrograde step. It is going back to that naming, blaming and shaming of individual practitioners. The literature and research show that a lot of the errors and adverse events that occur in medicine are the result of systemic issues and, unless we are able to bring them out into the open, we are unable to address those issues within our health system. If you just individually take out a doctor who you label as a bad doctor, often you just remove somebody who could be practising at a high level. That is the concern: that you are introducing this very punitive atmosphere for the profession, which has, I think, over the last 10 years tried to develop a just culture and bring those issues into the open.[71]

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68 *Proof Committee Hansard*, 14 July 2009, p. 65.

69 Health Practitioner Regulation National Law, Exposure Draft, clause 6, p. 8.

70 *Proof Committee Hansard*, 14 July 2009, pp 8-9.

71 *Proof Committee Hansard*, 14 July 2009, p. 17.

2.69 The MIIAA argued that existing ethical codes in the medical profession were adequate to ensure sufficient public protection; as such, mandatory reporting should not be included in the NRAS. It preferred that the mandatory reporting provisions be removed in favour of a 'code or guideline', such as the AMC code of conduct.[72]

2.70 There was widespread support for the view amongst the professions that the mandatory reporting provisions must include exemptions for 'therapeutic relationships' between medical professionals. The RACS, for example, submitted:

> While the mandatory reporting provisions of the legislation, contained in Sections 161 and 162, are supported, the College believes there should in addition be an exemption for those health practitioners who become aware of reportable conduct outside the workplace as the result of therapeutic or personal relationships.
>
> The College maintains its view that arrangements should not be such as to discourage a health practitioner from seeking assistance and opting instead to continue practising in an impaired state for fear that his or her treating practitioner would be obliged to report them.[73]

2.71 Dr David Hillis, Chief Executive Officer, RACS, explained:

> Bill B has already incorporated medicolegal issues such that if a practitioner becomes aware of this through a legal case they are protected. We think that also needs to be reflected in therapeutic situations. If a doctor, because they have a problem, is actually seeking help then they should not be penalised by mandatory reporting. In other words, if they have insight to the fact they have a problem and are actually seeking assistance for the problem, there should not be mandatory reporting of that, with all the issues being portrayed publicly, and they should be treated therapeutically first.[74]

2.72 On the issue of workplace relationships more generally, the APS commented

> …the whole notion of collegiate support, mentoring and even supervision are undermined by the provisions that have been made about mandatory reporting.
>
> …
>
> Even worse are the mandatory reporting requirements for employers…[For] many of our members their employer has nothing to do with the health system. Here we have a situation where an employer is threatened with sanctions if they do not report an employee who in their mind has a conduct or a performance problem. So…you would never have mentoring and supervision in a context where that threat hung over the employer. There is

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72 *Proof Committee Hansard,* 14 July 2009, p. 11. Information on the AMC code can be found at http://goodmedicalpractice.org.au.

73 *Submission 20a,* p. 3.

74 *Proof Committee Hansard,* 13 July 2009, p. 86.

> grounds for a vexatious employer to misuse those powers and certainly over reporting is likely to be a consequence. All of that is probably more damaging than the risks that are suggested by not having mandatory employer reporting..[75]

2.73 The ADA noted that the system of mandatory reporting as currently proposed could also have an impact on complaints resolution processes:

> For example, as written…[the NRAS] may preclude organisations such as professional associations undertaking and providing valuable assistance in the resolution of many complaints made by the public against health professionals. Often members of the public contact professional associations and raise issues of concern on a range of topics relating to treatment received. Such matters are regularly adjudicated or arbitrated upon to the satisfaction of all parties. The current wording of Section 156 may make it mandatory for the person (if they are a health practitioner) dealing with that matter to report on the issue. Persons fulfilling this valuable role for both the public and profession need to be excluded from the obligation to report on the conduct.[76]

2.74 A number of groups were also concerned that both formal and informal avenues of peer support would be undermined by mandatory reporting requirements unless appropriate exemptions were put into place. In relation to informal peer support, the PSA commented:

> Consideration must be given to encourage practitioners to seek early peer or medical support without fear of immediate mandatory reporting and to allow other practitioners, colleagues and employers to provide or support remedial action without being penalised.[77]

2.75 The RACGP commented:

> The legislation as it currently exists will cause medical and health practitioners to hide their impairments and professional issues from their colleagues, driving the issues underground and increasing rather than decreasing the risk to patients, the public, the practitioners themselves and their colleagues. We strongly believe that it is important to strengthen patient safety and improved standards; however, the mandatory reporting system as currently proposed is not, we believe, the solution.[78]

2.76 In relation to formal peer support services or networks, the MIIAA registered its concern that such services could be affected:

> Our concern is that doctors will not seek advice when they need it, that they will continue to operate without any supporting mechanism, and patients'

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75 *Proof Committee Hansard*, 13 July 2009, pp 33-34.

76 *Submission 31a*, p. 19.

77 *Submission 60a*, p. 4.

78 *Proof Committee Hansard*, 14 July 2009, p. 37.

> safety could potentially be compromised by that. Whereas, if they had sought assistance from the Doctors' Health Advisory Service or a similar service, they would have obtained assistance and addressed those issues and either had advice that said, 'You should report yourself', as insurers recommend, or had actually sought treatment for their problem.[79]

2.77 The ADA noted that the operation of its existing peer support service could be threatened:

> In most states the Australian Dental Association runs a complaints system for patients who have concerns with our members. They can have an easy and non-legalistic way of trying to resolve their problems…The people acting in that capacity would be covered by this mandatory reporting, and we believe they should not because they need to not be inhibited in that role.[80]

2.78 The PSA noted the success of the Pharmacist Support Service, which was a confidential peer support 24-hour phone service operating in Victoria since 1995. This service, providing information, support and referral to other services, provided valuable support to the profession, and was a model being considered as a national service, and by other professions. PSA submitted:

> PSA believes any mandatory reporting provisions under the NRAS must allow services such as PSS to continue its operations and therefore the impact on callers to the service and the volunteers must be clarified.[81]

2.79 Beyond the question of exemptions, the RACGP also felt that Bill B did not provide enough guidance on the scope of the requirement for mandatory reporting, particularly in relation to cases in which the issue of reportable behaviour was less clear.[82] The AMA shared this view:

> The definition of reportable conduct requires further consultation with the health professions. In effect, the relevant provisions in the draft Bill represent new mandatory reporting requirements across the health professions, as well as for the medical profession who are subject to existing state/territory laws. The draft definition in the Bill has a very broad application and there are considerable risks that health professionals will over-report, or not know when to report. We support suggestions by other health profession groups for educative scenarios to be provided to registrants so they have some certainty of what would be considered in scope as reportable conduct, before case law is established.[83]

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79 *Proof Committee Hansard,* 14 July 2009, p. 15.

80 *Proof Committee Hansard,* 13 July 2009, p. 46.

81 *Submission 60a*, p. 8.

82 *Proof Committee Hansard,* 14 July 2009, pp 40-41.

83 *Submission 29b*, p. 5.

2.80 Dr Morauta advised that the mandatory proposal had been on the agenda throughout the consultation process on the NRAS; and noted that the NRAIP had received a 'largely positive response' on its inclusion in the legislation, notwithstanding the issues raised before the Committee.[84]

Complaints

Separation of complaints management and performance management

2.81 The AMC submitted that the proposed complaints process was a 'retrograde step' in that it did not adequately separate performance management from complaints management. Mr Frank highlighted that performance issues should be clearly distinguished from complaints processes:

> Performance assessment…[is based on the] notion that if you could identify suboptimal performance before it became a problem and then put people through remediation programs or, if there is an impairment issue, into the appropriate impairment program then you could head off the potential problem down the track. It is really a risk minimisation and mitigation type of process, and it operates differently from the normal complaints process.[85]

2.82 Given this distinction, Mr Frank observed that performance assessment and management properly involved proactive processes, as opposed to the more reactive nature of complaints management.[86] The proposed Scheme did not adequately allow for these separate processes:

> …[In] the current wording of bill B there is a lack of flexibility in the complaints-handling process; in particular, the fact that it appears as though a case has to proceed to the end of one pathway before it can be shifted across to another pathway. If, for example, a case is identified, perhaps from a complaint, which really relates to a performance or impairment issue, it does not appear to be very simple to move it across into that other area. You have to progress all the way through to the end of the conduct or complaints process before you can move it across into the other areas. Again, we think that would slow the process down and add to the time it takes to process these cases.[87]

2.83 The AMC called for performance assessment to be separated from the complaints system, as per the current NSW and Victorian systems.

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84 *Proof Committee Hansard,* 14 July 2009, p. 67.

85 *Proof Committee Hansard,* 14 July 2009, pp 30-31.

86 *Proof Committee Hansard,* 14 July 2009, p. 20.

87 *Proof Committee Hansard,* 14 July 2009, p. 20.

Public Interest Assessor

2.84 Many groups commented on the proposed Public Interest Assessor (PIA). The functions of the PIA are outlined in clause 36 of Bill B:

> (a) assessing complaints made to the National Agency about health practitioners who are, or were, registered under this Law or a corresponding prior Act,
>
> (b) in conjunction with National Boards, deciding what action is to be taken in relation to complaints received by the National Agency,
>
> (c) any other function given to the Public Interest Assessor by or under this Law or by written instrument of the Ministerial Council.

2.85 The PIA was not originally proposed as part of the NRAS, and was included on the basis of the NRAIP consultations. A number of submitters and witnesses felt that there has been insufficient explanation of, or consultation over, the intended role of the PIA in the Scheme. The AMA submitted:

> …[The PIA concept] has been introduced at a very late stage of the implementation. As such there has been very little explanation about how the role and functions of the Public Interest Assessor will work in practice.[88]

2.86 Further, the PIA was not sufficiently well-defined in Bill B to allow a proper consideration of the likely effect or role of such an agency.[89] PIAC, although it supported in principle the role of the PIA, submitted that it was unclear:

> …whether in states and territories other than NSW and the ACT, there will be independent assessment, investigation and prosecution of health complaints about health professionals.
>
> The role of the Public Interest Assessor is crucial to answer this question. Clear information on how this body or person will be funded, the resources available to carry out their functions, and how their independence will be maintained appears not to be available at this time.[90]

2.87 Similarly, the RACGP commented:

> Whilst there is clear merit in such a position, we strongly believe that the public interest assessors' role should be better defined in the legislation, including the extent of their powers.[91]

2.88 The PSA, however, did not support the appointment of the PIA:

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88 *Submission 29b*, p. 2.

89 Dr Neil Hewson, President, ADA, *Proof Committee Hansard*, 13 July 2009, p. 51.

90 *Submission 85b*, p. 2.

91 *Proof Committee Hansard*, 14 July 2009, p. 37.

> We also regard the PIA to be unnecessarily duplicating the boards' tasks and role by having a parallel process in order to 'compare outcomes' at the end. The establishment of a PIA would certainly also require the scheme to allocate funding and resources in order to establish a team of staff.[92]

2.89 APodC expressed a similar view:

> …[The PIA] will inhibit the process of natural justice and produce unnecessary delays in the review and handling of matters, thus increasing costs to the profession and the community and duplication of similar services handled by peer review through the process of a professional board and supported by the relevant health complaints commission.[93]

2.90 The AOA also rejected the need for the PIA, on the basis that the position was open to influence form either the Ministerial Council and/or the National Agency.[94]

2.91 In response to the concerns outlined above, Dr Morauta provided a fuller account of the role of the PIA:

> …when the board first look at a complaint—the first time the complaint is there—they have to decide what to do with it…At that stage the public interest assessor would come in, look at what the board had done and have the option of saying, 'I think we need to have another look at this one. We need to do some more work on this one…'
>
> Similarly if the PIA says, 'I think that we should not take that one further,' but the board thinks that it should go further then the board takes it further. So it is a presumption that whoever thinks it needs a bit more looking at wins the argument. But then the board handles…[the complaint]; it is not given to somebody else to handle.
>
> In the second stage after an investigation…[a complaint] can either go to a tribunal…or it can be handled as a conduct matter by the board…Once again the public interest assessor…would come in and look at it with the board. If they wanted it treated more seriously…[and] the board did not then that would view would prevail.

2.92 Dr Morauta explained that the PIA had been introduced to the Scheme on the basis of feedback to the NRAIP from community groups, which wanted complaints to be subject to an independent source of assessment, as per the current approach in New South Wales.[95]

2.93 There was a widespread view amongst the professions that the cost of funding the PIA should be borne by governments rather than by the regulated professions (via registration fees). The ADA submitted:

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92 *Submission 60a*, p. 4.

93 *Proof Committee Hansard*, 13 July 2009, p. 2.

94 *Submission 6c*, p. 9.

95 *Proof Committee Hansard*, 14 July 2009, pp 68-69.

> It has been indicated that the cost of this new scheme is to be borne by the professions. The ADA objects to the creation of this new office and particularly on this basis. If this office is to be created then it should be at the cost of the Government concerned and not the profession.[96]

2.94 Dr Sorimachi commented:

> We understand that there will need to be a team of staff to support the public interest assessor, which will add to additional costs in terms of funding the operations and the resources.[97]

2.95 The OAA commented:

> ...We believe, as…[the PIA] is a consumer complaints protection mechanism, it is more appropriately resident in a Health Consumer Complaints Commission type of agency, which exist in every one of the states and territories in one form or another. Naturally, the cost of that office would be borne by the consumer complaints agency of each state and territory and not necessarily NRAS.[98]

2.96 On the issue of costs, Dr Morauta expected that jurisdictions may take different approaches, according to whether the PIA was purely an officer of the NRAS or connected to another entity:

> …[The question of funding will depend] on which way the individual jurisdictions go. So in the ACT you would expect them to say, 'Our PIA under this law is the HCC because it is exactly the same thing.' Some jurisdictions are looking at giving this role to their healthcare complaints commissioner, in which case it will be funded by government. It may not be a great deal of extra work in some jurisdictions; and in other jurisdictions it might be quite a lot of extra work for the healthcare complaints commissioner.
>
> So there is flexibility in the legislation for the role to be performed in different places, and some of those might be more efficiently done with the healthcare complaints commissioner, but it is up to the jurisdiction to decide that. Until the jurisdictions have decided, it is a bit difficult to see how much would actually come back to the registrants in terms of cost. We cannot anticipate that at this stage[99]

Protection of titles

2.97 Bill B provides for the protection of certain titles used by health professionals. Protection of titles through restricting their use to suitably qualified and recognised practitioners is necessary to ensure the integrity of accreditation registration processes.

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96 *Submission 31a*, p. 9.

97 *Proof Committee Hansard*, 13 July 2009, p. 99.

98 *Proof Committee Hansard*, 13 July 2009, p. 22.

99 *Proof Committee Hansard*, 14 July 2009, p. 69.

'Specialist'

2.98 A number of groups were concerned that the use of the term 'specialist' was to be available to practitioners with only limited registration—that is, practitioners who are registered to practise in only a limited area.

2.99 The AMA submitted:

> The draft Bill requires amendment to clarify that only medical practitioners who meet the requirements…[registration as a specialist in a recognised area of specialty for a health profession] are eligible for specialist registration and therefore entitled to use the title medical specialist…[Bill B] should be amended to remove the provision that permits a person who holds limited registration to use the title medical specialist.[100]

2.100 Dr Hillis explained:

> …there is…confusion in the terminology put against people who are registered as area of need practitioners. It has been suggested that they would then be able to use the word 'specialist'. The college would like to clearly state that they have not gone through the comparable or equivalent training program to be understood as a general medical practitioner. Consequently, they should not be using the words 'specialist medical practitioner'. What they have got is limited registration. An area of need position is limited geographically to a particular hospital that has the appropriate support for a practitioner who is not broadly trained or comparable.[101]

2.101 The RACS commented that the ability of practitioners with only limited registration to use the term 'specialist' had potential to cause 'substantial confusion in the mind of the public'.[102]

2.102 The RACGP submitted:

> …the RACGP believes that it is imperative that the public can identify the difference between a qualified medical specialist who has passed the assessment requirements for their medical speciality and a medical practitioner who is working in an area of need whose qualifications have not yet been determined to be substantially comparable. Therefore, we recommend either that all medical specialists use the title 'specialist' or that medical practitioners working in an area of need clearly define themselves, in a non-derogatory fashion, as not being a specialist—for example 'area of need general practitioner'.[103]

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100 *Submission 29b*, p. 5-6.

101 *Proof Committee Hansard*, 13 July 2009, pp 85-86.

102 *Proof Committee Hansard*, 13 July 2009, p. 82.

103 *Proof Committee Hansard*, 14 July 2009, p. 37.

2.103 The CPMC also called for the title of 'specialist' to be permitted to be used only by those practitioners who hold full specialist registration and are entitled to practise independently'.[104]

2.104 Dr Morauta acknowledged that the national consultation was considering submissions on this issue:

> At the moment, it is actually quite muddled out there. They are called all kinds of things, including specialists. But, when you have created a specialist register, you have created something whereby in the public domain you need to be able to distinguish between specialists who have the full qualifications for a specialist and specialists who have narrower qualifications. There is still quite a lot of discussion going on about how to handle that.[105]

Profession-specific titles

2.105 A number of professions advised that they were seeking protection of specific titles.

2.106 Professor Lyn Littlefield, Executive Director, APS, advised that the APS was seeking protection of a number of forms of the term 'psychologist':

> …protection of…[the term psychologist] alone is insufficient to protect the title of the profession and that it is necessary to add other variations and derivatives to protect the public from being induced to believe that a person is a psychologist. For instance, the title 'psychologist' and all adjectival derivatives such as 'psychological', 'in psychological services', 'psychological assessment' and 'psychological treatment' should be protected and reserved for the use by registered psychologists, whether they work in health or other fields of psychology and whether they provide direct service to individual clients or to groups and organisations, because the term 'psychological services' implies that the service is being delivered by a psychologist. We believe it is misleading to the public to use those terms where services are not delivered by a psychologist, as is currently the case. There are other professions which do deliver, particularly under things like Medicare, psychological services when they are not psychologists. We think that is misleading.[106]

2.107 The RACS was seeking protection of the terms 'surgeon' and 'specialist surgeon'. Dr Hillis explained:

> The main thing is to have an understanding that if a person is deemed to be a specialist surgeon they have gone through the appropriate degree of training, they have actually reached the required standards that a specialist

104 *Submission 15a*, p. 5.

105 *Proof Committee Hansard*, 14 July 2009, p. 73.

106 *Proof Committee Hansard*, 13 July 2009, p. 30.

surgeon should have. There is no doubt that other people will be practising minor surgery, but we believe that the title 'specialist surgeon' should be put into legislation.[107]

Spinal manipulation

2.108 Bill B provides:

> (1) A person must not perform manipulation of the cervical spine unless the person:
>
> (a) is registered in an appropriate health profession, or
>
> (b) is a student who performs manipulation of the cervical spine in the course of activities undertaken as part of an approved program of study in an appropriate health profession, or
>
> (c) is a person, or a member of a class of persons, prescribed under a regulation as being authorised to perform manipulation of the cervical spine.
>
> Maximum penalty: $30,000.
>
> In this section:
>
> **appropriate health profession** means any of the following health professions:
>
> - chiropractic,
> - osteopathy,
> - medical,
> - physiotherapy.
>
> **manipulation of the cervical spine** means moving the joints of the cervical spine beyond a person's usual physiological range of motion using a high velocity, low amplitude thrust.[108]

2.109 There was agreement among the various bodies representing the chiropractic profession that the proposed restriction on spinal manipulation was inadequate, because it applied a restriction only to manipulation of the cervical spine. Ms Krystina Brown, Chief Executive Officer, Chiropractors Association of Australia (CAA), explained:

> This regulation restricts the performance of manipulation of the cervical spine, commonly the neck, to chiropractors, osteopaths, medical practitioners and physiotherapists. Whole spine manipulation—that is, complete spinal manipulation—is not restricted under the draft bill in any way and therefore under the proposed legislation spinal manipulation could be performed by any person. The Chiropractors Association of Australia, or

107 *Proof Committee Hansard*, 13 July 2009, p. 84.

108 Health Practitioner Regulation National Law, Exposure Draft, clause 137, p. 67.

> CAA, is of the opinion that the proposed legislation has seriously compromised patient safety and quality of care and as a result will permit unnecessarily increased risks to Australians.[109]

2.110 The CAA submitted that spinal manipulation procedures performed by unqualified persons carried the risk of 'serious injury'.

> …the CAA does not support the separation of cervical manipulation from the term spinal manipulation in regard to restriction of practice, as serious injury may result from manipulation of all areas of the spine, including cervical, lumbar and low back.[110]

2.111 Appearing before the Committee, the CAA representatives described numerous potential risks for patients undergoing spinal manipulation in the lumbar and thoracic regions.[111]

2.112 This view of the CAA was supported by the ACCRB, which submitted that the removal of the restriction amounted to the removal of a protection to the public, and was therefore in breach of the first objective of the NRAS.[112] The AOA also supported these views.[113]

2.113 Chiropractor groups understood that the lesser restriction on spinal manipulation as contained in Bill B was based on the conclusion that there was 'insufficient evidence that restricting spinal manipulation reduces public risk'.[114] This position was based on the experiences of jurisdictions which did not have the broader restriction on spinal manipulation (currently, six of the eight state and territory jurisdictions restrict the manipulation of the spine or spine and pelvis).[115] All parties agreed that there was little statistical or formal evidence of higher rates of spinal injury in these jurisdictions.

2.114 However, the CAA observed:

> It is not unreasonable to assume that there would be little evidence available as injuries to citizens resulting from care provided from unregulated practitioners performing unrestricted practices would not necessarily be reported to a regulating authority. In many cases too, such practitioners would not be covered by professional indemnity insurance.
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> …

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109 *Proof Committee Hansard,* 13 July 2009, p. 69.

110 *Submission 99,* p. 5.

111 *Proof Committee Hansard,* 13 July 2009, pp 72-73.

112 *Submission 80a,* p. 2.

113 *Submission 6c,* pp 1-5

114 *Submission 99,* p. 4.

115 *Submission 99,* p. 4.

> Although there is little evidence available to suggest that the community is more vulnerable in those jurisdictions where no restrictions apply, compared with those where restrictions do apply, the CAA asserts strongly that the public should be legally protected from persons who are unskilled, unqualified, insufficiently trained and not competent to undertake manipulation of the spine.[116]

2.115 The CAA submission referred to 'considerable information in the literature relating to injuries or other adverse events that have occurred in jurisdictions where spinal manipulation is not restricted'.[117]

2.116 The ACCRB submitted:

> The Boards contend that, in the six jurisdictions where it has been illegal for unqualified people to manipulate the spine for the last 30 years, instances of spinal manipulation by people without legitimate training have been minimal due to the restrictions.
>
> A recent review of complaints made to the NSW Chiropractors Board over a period of thirty years revealed numerous complaints about unregistered people in the first 5 – 10 years but only rare instances in the last 20 years.[118]

2.117 Chiropractor groups also called for the restriction on spinal manipulation to be broadened to exclude health practitioners that were not specifically registered and/or suitably qualified to perform spinal manipulation. The CAA submitted:

> …the CAA strongly…[advocates] that manipulation of the spine and extremities be restricted to registered chiropractors and osteopaths, or those other registered health practitioners who can demonstrate equivalency of competence by appropriate, accredited, prescribed and clearly identified post-graduate training – eg musculo-skeletal physiotherapists. Medical practitioners have no relevant training for spinal manipulation in their undergraduate training and should also be required to demonstrate equivalency of competence via appropriate prescribed post-graduate training.[119]

2.118 Accordingly, the CAA recommended:

> To ensure that this happens the CAA believes that Bill B should be amended to reflect that:
>
> manipulation of the spine and extremities be restricted to registered chiropractors and osteopaths, or those other registered health practitioners

116 *Submission 99*, p. 4.

117 *Submission 99*, pp 8-11.

118 *Submission 80a*, p. 2.

119 *Submission 99*, p. 5.

> who can demonstrate equivalency of competence by appropriate, accredited, prescribed and clearly identified post-graduate training.[120]

2.119 Similarly, the ACCRB called for completion of an accredited course in spinal manipulation to be a requirement attached to the restriction on spinal manipulation in Bill B.[121]

Consultation on the NRAS

2.120 PIAC submitted that the time allowed for consultation on the NRAS was insufficient:

> PIAC has previously called for extensive public consultation, in all states and territories, including consultation outside the capital cities, on all aspects of the scheme for national registration of health professionals. Sadly PIAC has seen no evidence that this is planned, and fears that legislation will be passed without adequate public debate, in order to meet the timetable to have the changes in place by 2010.[122]

2.121 The AMC was concerned that the present timetable would not allow for the changes to Bill B arising from consultation on the exposure draft to be considered by the professions, particularly those relating to the complaints process. Mr Frank commented:

> The one concern we have…[is] that once we and all health professionals and other stakeholders have made their submissions we will not actually get to see another version of this bill. It will go straight to the Queensland parliament and enter into that process for debate. The concern we have is that the complaints process in particular is a really critical part of this exercise. If it were at all possible to at least have that section of the bill viewed by the people who actually operate the complaints processes, it would be very valuable in ensuring that when the thing is finally implemented it actually does work in the field. We have some concerns that, as currently written, that may not be the case.[123]

2.122 The Pharmacy Guild of Australia (PGA) was also critical of the timing of the consultation/implementation processes around Bill B, noting that there was just five weeks allowed for the public consideration of the exposure draft legislation. The PGA submission noted:

> As the legislation is endorsed by the Australian Health Workforce Ministerial Council, the Guild understands that comments received on the exposure draft will be presented to the Queensland Parliament for processing, without any particular opportunity by the professions for

120 *Submission 99*, p. 5.

121 *Submission 80a*, p. 3.

122 *Submission 85b*, p. 2.

123 *Proof Committee Hansard*, 14 July 2009, p. 21.

> amendment.. It is highly undesirable for legislation to be put through a parliamentary process without a quality assessment of the policy of a proposition and any legislation giving effect to policy.[124]

Profession-specific issues

2.123 The following issues were raised as particular issues in relation to individual professions.

Podiatry

Specialist registration

2.124 APodC and the Australasian College of Podiatric Surgeons (ACPS) were concerned about specialist areas of practice in podiatry that were not to be recognised in the Scheme as proposed in Bill B, notably:

- sports podiatry (with specialists having attained a qualification of Fellow of the Australasian Academy of Podiatric Sports Medicine); and
- podiatric surgery (with specialists having attained a qualification of Fellow of the Australasian College of Podiatric Surgeons).[125]

2.125 The Committee notes that Bill B proposes recognition of specialist health areas only in relation to the medical and dental professions.[126] The January 2009 consultation paper notes:

> For the purposes of transition [to the Scheme], from July 1 2010, initial regulation of specialists in any profession will be by an endorsement on the public register…In the absence of such a standard being in existence at the time of transition to the scheme, the registrant will only be granted general registration without specialist endorsement.[127]

2.126 Mr Peter Lazzarini, Vice President, APodC, advised that the original consultation paper on specialist registration had indicated that podiatry would be included amongst the professions recognised as specialist professions from the inception of the Scheme:

> [The] consultation paper clearly stated, under 'Registration arrangements for registered podiatrists', proposal 10.1.3, that there be an offence for a person who is not a registered podiatrist with endorsement as a podiatric surgeon to hold himself out as a podiatric specialist. However, the exposure

124 *Submission 95a*, p. 5.

125 *Proof Committee Hansard*, 13 July 2009, p. 2.

126 Health Practitioner Regulation National Law, Exposure Draft, clause 12, p. 12.

127 Cited at *Proof Committee Hansard*, 13 July 2009, p. 3.

> draft for bill B does not include podiatric surgeons as a specialist category. This is of great concern to the APodC and many within the profession…[128]

2.127 Dr Mark Gilheaney, President, ACPS, noted that there had been no formal or official justification provided as to the reason(s) for the omission of podiatric surgery from the specialist professions. However, there had been informal indications that its omission was due to perceptions that it did not have 'a fully functioning AMC-style of accreditation'.[129]

2.128 Podiatrists identified a number of issues arising from the failure to recognise podiatry as a specialist profession. Primarily, it was argued that this approach was not in the public interest, as it might place the public at risk. Dr Gilheaney explained:

> If the law is open, any podiatrist under an act of parliament could operate on you tomorrow if they get informed consent from you. There is no law that says any podiatrist cannot perform surgery right now, but all registration boards at the moment only allow you to do so if you are an accredited podiatric surgeon/specialist podiatric surgeon…The podiatry profession has an existing, long-held framework for control and regulation of specialist practice. You might argue that it is not as strongly accredited as the AMC style of accreditation, but I would suggest to you that it is a long way…Do not throw out what is there. Leave it in place and improve on what is there, because the bottom line is protection of the public.[130]

2.129 In addition, it was claimed that the failure to extend specialist recognition to podiatry could impact on the functions of the National Board, which might be unwilling or reluctant to allow general registration for podiatric surgeons where it would 'not have the ability to identify whether those surgeons had taken part in ongoing collegiate activity for peer review, standards review [and] ongoing education'.[131]

2.130 Lastly, the failure to provide a specialist register for podiatric surgery could also reinforce barriers to podiatrists contributing to competition and therefore efficiency in the 'surgical marketplace', an outcome that would ultimately be against the spirit of the Intergovernmental Agreement.[132]

2.131 The podiatry groups called for the profession to be 're-included' as a profession eligible for specialist registration from 1 July 2010 on a number of grounds. These were summarised in the APodC supplementary submission:

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128 *Proof Committee Hansard*, 13 July 2009, p. 3.

129 *Proof Committee Hansard*, 13 July 2009, p. 7.

130 *Proof Committee Hansard*, 13 July 2009, p. 8.

131 Dr Mark Gilheaney, President, ACPS, *Proof Committee Hansard*, 13 July 2009, p. 8.

132 *Proof Committee Hansard*, 13 July 2009, p. 4.

> In the area of podiatry, a number of recognised, well established specialisations already exist with podiatric surgery and sports podiatry. These professions have professional organisations, qualifications for acceptance and recognition as a Fellow, conduct research and hold scientific conferences…Podiatric surgeons currently have specialist registration in South Australia and Western Australia, with all podiatry registration boards recognising the specialist training and qualifications of podiatric surgeons. Whilst podiatric physicians have specialist registration on the Podiatry Board of Western Australia, both podiatric physicians and podiatric surgeons are on similar specialist registers in most other states.[133]

2.132 More generally, APodC observed that, by recognising only the medical and dental professions, the Scheme would fail to encompass both established and emerging areas of specialty practice:

> The national scheme is missing the opportunity to fully recognise the established, developing and evolving nature of health care by not recognising any specialist health professions other than those in the medical and dental professions. Health care, like many skilled professions across a wide range of areas, is becoming more complex and involved and therefore has undergone and is undergoing greater specialisation amongst members of the various professions.[134]

2.133 In the event that podiatry was not recognised as a specialist profession from the inception of NRAS, podiatrists asked whether podiatric surgeons would not be able to practise in this area until their inclusion on a specialist register. Dr Gilheaney observed:

> There can be no logic in making us wait to go through the bureaucratic process over the next two to five years. The current standards of national recognition and accreditation of podiatric surgery should be maintained and built upon, not stripped back, in a process that will be mapped to ensure compliance with the new principles of national registration and accreditation.[135]

2.134 Mr Lazzarini also questioned the necessity of podiatric surgery being required to undertake the process of approval for a specialist register once the new scheme commences:

> …why we should go back through the processes that have already been through the states to get back to point 1 to move on from point A to point B again…[We] are asking why we should start that process again when it has already been through most of the states to have a specialist register.[136]

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133 *Submission 77a*, p. 3.

134 *Proof Committee Hansard*, 13 July 2009, p. 2.

135 *Proof Committee Hansard*, 13 July 2009, p. 5.

136 *Proof Committee Hansard*, 13 July 2009, p. 13.

2.135 However, Dr Morauta noted that Bill B provided for states or territories with areas of specialist registration prior to 1 July 2010 to retain those areas 'until such time as the consideration of the specialist registration in that profession has run its course'.[137]

Optometry

Exemption of orthoptists from optometrist practice restrictions

2.136 Optometrists were concerned that, under the proposed Scheme, orthoptists would be able to prescribe 'optical appliances', namely spectacles. Orthoptists are allied health professional who diagnose and treats patients with eye alignment and eye movement disorders as well as binocular vision disorders.

2.137 The exemption in question is contained in clause 136(1)(b) of Bill B:

> A person must not prescribe an optical appliance unless:
>
> (a) the person is registered in the optometry or medical profession, or
>
> (b) the appliance is spectacles and the person is an orthoptist who prescribes the spectacles:
>
> (i) in the course of carrying out duties at a public health facility, or
>
> (ii) under the supervision of, or at the request of or on referral from, a person registered in the optometry profession or medical profession,

2.138 The OAA noted:

> …the Intergovernmental Agreement signed by the Australian Government and all States and Territories last year specified that the practice of optometry would be restricted in the National Law to prevent practice by unregistered or unauthorized persons…[Clause] 136 as it is now undermines that clear intention.[138]

2.139 Further, the OAA was concerned that the exemption would:

- reduce the protection presently provided to the public by current regulation of optometric practice.
- impose deregulation on jurisdictions which have previously decided against deregulation.
- be contrary to Australian Government policy as well as the Intergovernmental Agreement which established the national registration and accreditation scheme.
- allow orthoptists to operate in an area of restricted practice without the obligations required of registered professions such as independent

137 *Proof Committee Hansard*, 14 July 2009, p. 74.

138 *Submission 40a*, p. 5.

> accreditation, mandatory insurance and continuing education or government supervised registration.[139]

2.140 Specifically, the OAA noted that three states currently allow orthoptists to prescribe spectacles: Victoria, South Australia and New South Wales. However, each of these states imposed restrictions or protections, such as:

- a requirement that this is only done on recent referral by an optometrist or ophthalmologist (Victoria and South Australia); or
- a requirement that this is only done by an orthoptist employed in a public health facility or by an opthalmologists (Victoria and South Australia); or
- a requirement that an orthoptist may only prescribe within six months of an ocular health examination by an optometrist or ophthalmologist and then only on written referral by the examining optometrist or ophthalmologist (NSW).

2.141 The ACT, Queensland, Tasmania, Western Australia and the Northern Territory did not allow orthoptists to prescribe spectacles.

2.142 Mr Chakman explained the public health policy rationale for the restriction on the prescribing of spectacles:

> …the restricted area of practice for optometry is the prescription of spectacles. No-one can prescribe spectacles apart from an optometrist or a medical practitioner. It is not that prescribing spectacles is dangerous; nobody makes that claim. The reason for the prohibition is that before prescribing a pair of spectacles one has to actually ascertain what is leading to the loss of vision, so it is actually a public health measure.[140]

2.143 Mr Chakman observed that orthoptists did not practise under systems that would necessarily ensure such public health goals:

> Orthoptists currently are not registered in any jurisdiction in Australia. They would be given rights to practise that only optometrists have without all the responsibilities that the optometrists would have. There is no requirement that they be registered. There is no requirement that they have insurance. There is no requirement they maintain their educational standards and quality of service. There is no way of actually penalising them or disciplining them if they behave in the wrong sort of way.[141]

2.144 The OAA noted that the requirements in states that currently allowed orthoptists to prescribe spectacles were designed to ensure a proper assessment of whether vision loss in a given case was caused by an underlying disease:

> States and Territory governments restrict prescribing of optical appliances to optometrists and medical practitioners to ensure that disease is excluded

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139 *Submission 40a*, p. 3.

140 *Proof Committee Hansard*, 13 July 2009, p. 24.

141 *Proof Committee Hansard*, 13 July 2009, p. 25.

> as a cause of vision loss. To illustrate, diabetes can cause shortsightedness and an inadequately trained person may successfully prescribe to solve the shortsightedness without recognising that diabetes is present.
>
> As noted above, even the three States which allow orthoptists to prescribe do so with the implicit or explicit requirement that full ocular examinations by optometrists or ophthalmologists will have first excluded eye disease as a possible cause of vision loss.[142]

2.145 The OAA objected that Bill B as currently proposed would 'impose [on all states] the weaker of the protections for patients now in place in the three states which permit orthoptists to prescribe'.[143] If the lowering of the restriction were to proceed, the OAA felt that the more stringent requirements imposed by NSW, outlined above, should apply.

2.146 However, the OAA recommended that clause 136(1)(a) be deleted on the basis that 'early detection and prevention are best served by encouraging regular ocular health examinations rather than facilitating ways by which such examinations will be avoided'.[144] The National Board would still retain the ability to allow orthoptists to prescribe:

> The proposed S 136 (1) (d) could enable the new Optometry Board of Australia to allow restricted prescribing by orthoptists if after proper consideration of the issue it concludes that such exemption is justified.[145]

2.147 Dr Morauta noted that this issue had been raised in the course of the national consultation process.[146]

Uniformity of state and territory laws outside NRAS

2.148 The OAA identified a number of areas falling outside NRAS in which it was desirable to ensure national uniformity. These are:

- drugs and poisons legislation; and
- supply of optical appliances.

2.149 The OAA advised that, because prescription of drugs and poisons is covered by state regimes, differences in those regimes could mean that practitioners working across jurisdictions could inadvertently breach different requirements. Such breaches could see the National Board involved in disciplinary actions in relation to conduct which was allowed in one jurisdiction but not in another.[147] Mr Andrew Harris,

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142 *Submission 40a*, p. 5.

143 *Submission 40a*, p. 5.

144 *Submission 40a*, p. 5.

145 *Submission 40a*, p. 4.

146 *Proof Committee Hansard*, 14 July 2009, p. 72.

147 *Submission 40a*, p. 6.

President, called for uniformity in this area to be 'encouraged to ensure that there is a consistent drug list across the nation'.[148]

2.150 Supply of optical appliances (as opposed to prescription) is not covered by the national law. The OAA submitted:

> The supply of contact lenses in particular by unqualified people is a health risk in that contact lenses can damage vision and even cause blindness. SA and Tasmania presently restrict the supply of contact lenses to registered persons. Optometrists Association urges all States and Territories to consider uniform legislation which requires that a valid prescription from a registered practitioner with an expiry date should be required before spectacles and contact lenses can be supplied.[149]

2.151 OAA acknowledged that these areas fell outside the proposed national scheme, but noted that the operation of NRAS could be impacted on by inconsistent state and territory regimes governing areas closely related to professional practice.[150] The OAA felt that the development of the national scheme should be taken as an opportunity to also address any such inconsistencies.

Psychology

Adequate recognition of organisational psychologists

2.152 The Australasian Psychological Society of Organisational Psychologists (APSOP) expressed concern that the move to 'generic health practitioner legislation' under NRAS would undermine recognition of organisational psychologists as a specific branch of practising psychology.

2.153 APSOP noted that health services represented 'but one aspect of professional psychological practice'.[151] Accordingly, the NRAS should recognise and accommodate psychology services more broadly in respect to complaints, specialist tertiary training and continuing professional development. Equally, APSOP was concerned that future workforce planning should take into account the workforce needs of organisational psychologists as part of psychologists more broadly.[152] Professor John O'Gorman, Member, APSOP, outlined a number of 'distortions' that might arising from Bill B's failure to distinguish organisational psychology from health delivery:

> You may ask: is there any harm in continuing, for administrative convenience, the fiction that professional psychology can be taken to mean

148 *Proof Committee Hansard,* 13 July 2009, p. 16.

149 *Submission 40a*, p. 6.

150 *Proof Committee Hansard,* 13 July 2009, p. 26.

151 *Proof Committee Hansard,* 13 July 2009, p. 31.

152 *Proof Committee Hansard,* 13 July 2009, p. 31.

> health delivery, as bill B seeks to do? We consider there is. We have already seen in some state jurisdictions the distortions that arise when all psychologists are considered to be health practitioners. The distortions result from the training placements probationary psychologists are required to undertake and the competencies they are expected to demonstrate, requirements that are appropriate for clinical work but limit the time and sap the interest in training for those not wanting to assess abnormal personality or mental dysfunction or to engage in long-term mental health treatment.[153]

2.154 In relation to complaints, APSOP was concerned that people might be denied access to the NRAS complaints system where they were users of psychological services that were not health related.[154] Professor O'Gorman explained:

> … a client who has sought career or vocational guidance or has undergone a process of employment testing and assessment, or an employer who has sought the services of a psychologist to deal with conflict in a work team or to assist in the management of change in an organisation, has not been rendered a health service or even a health related service but has been provided a service which nonetheless has serious implications for people's lives and livelihoods.[155]

2.155 Although Bill B defined all services provided by psychologists as 'health services', APSOP was concerned that other complaints bodies, such as tribunals and health complaints bodies, might not be able to hear complaints that can not be strictly defined as health matters.[156] To address its concerns APSOP called for broad representation of psychologists on all boards established under NRAS and a transparent complaints procedure that will allow the hearing of all complaints against psychologists.[157]

Scope of practice in psychological testing

2.156 The APS called for protections or restrictions on the administering of psychological tests, on the basis that misdiagnosis or otherwise incorrect diagnosis can have lasting negative effects on a person's life and prospects.[158]

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153 *Proof Committee Hansard,* 13 July 2009, p. 31.

154 *Proof Committee Hansard,* 13 July 2009, p. 32.

155 *Proof Committee Hansard,* 13 July 2009, p. 32.

156 *Proof Committee Hansard,* 13 July 2009, p. 32.

157 *Proof Committee Hansard,* 13 July 2009, p. 32

158 *Proof Committee Hansard,* 13 July 2009, p. 31.

Pharmacy

Registration of pharmacy premises

2.157 The PGA supported national registration of health practitioners. However, the Guild recommended that the NRAS, as envisaged, not proceed. The PGA supported instead a co-regulatory model which:

> …creates a national Pharmacy Board comprised of representatives from each jurisdiction's pharmacy board and appropriate representatives from relevant pharmacy organisations and consumers to approve (after full consultation with stakeholders) national registration and accreditation standards following policies developed by the Australian Health Workforce Ministerial Council; but retains State and Territory registration boards to perform the initial registration, and subsequent discipline of, practitioners as well as any other powers of functions conferred on the board by legislation of the jurisdiction…[159]

2.158 The Guild argued that the company-regulatory approach was better suited to pharmacy profession, given that the regulation of pharmacy premises was to remain outside the national Scheme:

> …the guild believes that it is important to keep the current pharmacy boards in each state and territory in place both because of their significant knowledge as to how pharmacy operates in those jurisdictions but also because they are responsible for administering in the interests of the public the state and territory pharmacy acts. Under these acts, pharmacy boards are responsible for ensuring that pharmacies are only owned by properly qualified pharmacists and in most states that pharmacies are properly registered and meet the standards required by law. The most important point that we want to make is that the professional practice of community pharmacists is inextricably linked with the pharmacy premises in which they handle and dispense medicines to the public.[160]

2.159 Ms Wendy Phillips, Executive Director of the PGA, was concerned that under the new Scheme there would be no financial provision in relation to administration and oversight of registration of pharmacy premises:

> The point is that boards at the moment receive fees both for registration of pharmacists and registration of premises. That enables them to have enough money to operate with one staff member, perhaps, looking after both functions. Once you split it and the funding is taken away for this scheme, to try to set up some new body to look after registration of premises is probably financially unviable.[161]

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159 *Submission 95a*, p. 10.

160 *Proof Committee Hansard*, 13 July 2009, p. 55.

161 *Proof Committee Hansard*, 13 July 2009, p. 58.

2.160 Ms Phillips advised that there was considerable uncertainty as to how registration of pharmacies would be continue to be overseen by the profession once the new Scheme commenced:

> …[Ongoing oversight will depend] on what is extracted from the existing acts to become part of this scheme and then what is left behind and how that is housed in state and territory legislation. In the case of states where there is a separate pharmacy act, that act could just be left there. But then we are not sure who would administer it, because the board would have been abolished. In the bigger states they could probably set up a statutory authority of some sort. We have tried to look at developing business plans about setting these kinds of bodies up. We know from looking at it that it would not be financially viable in the smaller states unless you charged the pharmacists very high fees, which would be unfair.[162]

2.161 Both the PGA and the PSA observed that under NRAS the National Board would be able determine whether a state or territory board was required. Where a state or territory board was not required, the question of how the pharmacy ownership and registration issues would be overseen was even more acute. Dr Sorimachi commented:

> …our main concern is that, because under the national registration scheme it is left up to the national board to determine whether a state or territory board is required, there could be scope for those bodies to be no longer present in the jurisdictions. We believe that pharmacy ownership issues and premises registration issues are fundamental to the practice of community pharmacy and therefore we do have perhaps a greater interest in maintaining the state and territory bodies.[163]

Accreditation of specialist pharmacist practitioners

2.162 The PSA submitted:

> The legislation needs to take account of details around the accreditation (credentialing) of specialist pharmacist practitioners (as distinct from the accreditation of programs of study). In this regard, the role of the Australian Association of Consultant Pharmacy (a body which currently accredits pharmacists in specialist areas of pharmacy practice) under the new scheme requires clarification.[164]

Chiropractic

Provision of chiropractic services about the jaw

2.163 The CAA submitted:

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162 *Proof Committee Hansard*, 13 July 2009, p. 60.

163 *Proof Committee Hansard*, 13 July 2009, p. 94.

164 *Submission 60a*, p. 3.

> There is a concern that the Dental restricted practice in Bill B "Subdivision Practice Protections 135 Restricted dental acts" needs to be clarified so that the normal scope of chiropractic practice is not restricted.
>
> Chiropractors provide services where the chiropractor examines, diagnoses, provides treatment in/around/to the mouth, jaw, musculature of the jaw, TMJ, and cranial regions.[165]

2.164 The ACCRB and AOA were also concerned that the proposed restricted dental practice in Bill B impinges on the normal scope of chiropractic practice.[166]

Midwives

Issues relating to registration and indemnity insurance

2.165 Clause 69 of Bill B sets out the eligibility requirements for general registration in a health profession. These include, inter alia, that a practitioner or their employer is covered by 'appropriate professional indemnity insurance arrangements'.[167]

2.166 The Committee received a considerable number of submissions from midwifery groups, midwives and individuals commenting on the potential effect of the requirement for professional indemnity insurance on midwives, particularly those in independent or private practice.

2.167 This and related issues will be addressed by the Committee in its report on the Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills, as these Bills interrelate on this critical issue. The Committee is concerned that the impacts of this legislation on midwives and the options for home birth in Australia are taken into account.

CONCLUSION

2.168 The evidence received by the inquiry indicated general support for the NRAS across the health professions to be regulated under the Scheme.

2.169 The Committee notes that the there was a considerable reduction in the objections or concerns about the design of the Scheme between the initial consultations and the release of the exposure draft of the Health Practitioner Regulation National Law (Bill B). The Committee congratulates the implementation team and the Ministerial Council on the success of the national consultation to date in identifying and responding to a large number stakeholder concerns.

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165 *Submission 99*, p. 6.

166 *Submission 80a*, p. 4; *Submission 6c*, p. 5.

167 Health Practitioner Regulation National Law, Exposure Draft, p. 36.

2.170 The Committee observes that, across the course of the inquiry, the issue of greatest concern to the regulated professions was to ensure the independence of the accreditation processes and entities under the NRAS. Stakeholders noted that the majority of these issues were addressed in the design of Bill B.

2.171 However, the majority of submitters and witnesses expressed concern that there remained the potential for government interference or influence in accreditation processes, through the power given to the Ministerial Council to issue directions to the National Agency and/or National Boards in relation to accreditation standards, in circumstances where a standard 'may have a substantive and negative impact on the recruitment or supply of health practitioners to the workforce'.

2.172 In general, stakeholders agreed that the proposed power was inappropriate to the extent that it could ultimately lead to a lowering of standards in order to increase the recruitment and/or supply of health practitioners to the workforce. There was a range of recommendations put forward as to how to constrain or amend the proposed power.

2.173 While the Committee acknowledges the importance of the issue of workforce supply in the area of heath—particularly for regional and remote areas—the Committee notes that, on the face of the proposed provision, there is a lack of clarity around both the scope of the power in practice, and the extent to which its exercise will take into account, or be constrained by, public health and safety considerations.

2.174 For these reasons the Committee commends Recommendation 1 above to the Australian Health Workforce Ministerial Council.

2.175 Further, the Committee considers that, given the importance of issues relating to accreditation standards and workforce supply, the operation of the Scheme and the public interest would benefit if the reasons of the Ministerial Council in issuing any such direction were required to be made public.

Recommendation 2

2.176 The Committee recommends that the Australian Health Workforce Ministerial Council introduce a requirement into the proposed national registration and accreditation scheme (NRAS) that the reasons for issuing a direction in relation to an accreditation standard be made public.

2.177 The Committee notes that many of the regulated professions were concerned about the composition of the National Boards which would result from the formula provided in Bill B. In particular, there were concerns that (a) mandatory requirements for representation of jurisdictions could exclude appropriate expertise and (b) that smaller jurisdictions would not be adequately represented. The Committee notes that a one-size-fits-all approach to the formation of the National Boards is unlikely to deal satisfactorily with the individual characteristics of the individual professions. Given this, the Committee considered that the power given to the Ministerial Council to decide the size and composition of a National Board should not be overly constrained

by the formula provided in Bill B concerning the composition of the Boards. The Committee therefore urges the Ministerial Council to ensure there is sufficient flexibility in the NRAS to ensure that the representation of National Boards properly reflects the characteristics and needs of the individual professions.

Recommendation 3

2.178 The Committee recommends that the Australian Health Workforce Ministerial Council ensure that the national registration and accreditation scheme (NRAS) contains sufficient flexibility for the composition of National Boards to properly reflect the characteristics and needs of the individual professions.

2.179 Evidence from psychology associations indicated that that profession is unique to the extent that it might be considered to have health and non-health streams; and that the NRAS as proposed needs to better accommodate these different streams in the design of its accreditation, registration and complaints processes. While the Committee did not consider it appropriate to make a particular recommendation on this issue, it draws attention to the issue as one that should have further consideration in the final stages of the national consultation.

2.180 Evidence from the pharmacy profession revealed a widespread concern about the funding and administration and oversight of pharmacy premises registration following the start of the NRAS. The Committee also draws attention to this issue as one that merits serious attention from the Ministerial Council to ensure that appropriate and detailed transition plans are in place for the various jurisdictions.

Senator Claire Moore
Chair

August 2009