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COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: National registration and accreditation scheme for doctors and other health workers

MONDAY, 13 JULY 2009

CANBERRA

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Monday, 13 July 2009

Members: Senator Moore (*Chair*), Senator Siewert (*Deputy Chair*), Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Furner, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Abetz, Boyce, Carol Brown, Furner, Humphries, Moore and Williams

Terms of reference for the inquiry:

To inquire into and report on:

The design of the Federal Government's national registration and accreditation scheme for doctors and other health workers, including:

- a. the impact of the scheme on state and territory health services;
- b. the impact of the scheme on patient care and safety;
- c. the effect of the scheme on standards of training and qualification of relevant health professionals;
- d. how the scheme will affect complaints management and disciplinary processes within particular professional streams;
- e. the appropriate role, if any, in the scheme for state and territory registration boards; and
- f. alternative models for implementation of the scheme.

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Committee met at 9.02 am**GILHEANY, Dr Mark Francis, President, Australasian College of Podiatric Surgeons****BROWN, Mr Brenden, President, Australasian Podiatry Council****LAZZARINI, Mr Peter Anthony, Vice-President, Australasian Podiatry Council****WHICKER, Dr Susan, Chief of Staff, Australasian Podiatry Council**

CHAIR (Senator Moore)—Good morning, everybody. This is the second hearing of the committee's inquiry into the national registration and accreditation scheme for doctors and other health workers. The committee notes that a national consultation process on the registration and accreditation scheme is being undertaken through the Australian Health Ministers Advisory Council and that that process is in its final stages. The number of hearings originally planned for this inquiry has been reduced to allow for the work of the committee to contribute to, rather than lead, the national consultation process. Our first witnesses this morning are from the Australasian Podiatry Council. Do you wish to comment on the capacity in which you appear?

Mr Lazzarini—I am a registered podiatrist in the sunshine state, the state of Queensland.

Mr Brown—I am a registered podiatrist in New South Wales.

Dr Gilheany—I am President of the Australasian College of Podiatric Surgeons, which is an organisation affiliated with the Australasian Podiatry Council.

CHAIR—Information on parliamentary privilege and the protection of witnesses and evidence has been provided. I invite any or all of you to make an opening statement if you would care to do so, and then we will go to questions from the committee. Who is going to lead off?

Mr Brown—The Australasian Podiatry Council—we will refer to ourselves as APodC—is the only professional representative organisation for podiatrists in Australia and New Zealand. We represent approximately 80 per cent of practising podiatrists in Australasia. Individual podiatrists are members of their member organisation or the Podiatry New Zealand organisation, and they are subsequently members of our organisation. We represent those bodies. The APodC fulfils many important roles for podiatrists and the podiatry profession, including liaising with and lobbying government at all levels on issues of importance to the profession, such as the hearing today; the development of national policies and clinical practice guidelines; and representation on industry bodies such as Allied Health Professions Australia and the National Primary Health Care Partnership. We support the Australian Podiatry Education and Research Foundation, providing accreditation to overseas trained podiatrists.

The profession is an integral part of the health service landscape in Australia. One in five Australians at any one time will have foot pain, so we represent the 20 per cent of the population running around the place at the moment who have sore tootsies. In 2007-2008, through the Enhanced Primary Care program, we provided 491,000 MBS services, which cost approximately \$23 million. That makes us the largest provider in EPC of MBS items for the allied health group that have five visits. We provided 830,000 DVA consultations in 2007-2008, which cost

approximately \$51 million. More than 128,000 bed days will be taken up in any one year due to diabetic foot ulcers. We believe that diabetics can be provided with some protection if they are serviced by podiatrists. Up to 80 per cent of ulcerations and amputations, and costs, can be prevented with management from a multidiscipline area foot team, which necessitates the role of podiatrists.

With regard to the issues at hand today, with regard to our accreditation, while the APodC supports a national scheme, from the perspective of national registration for the profession we have a number of concerns specific to the proposed process to support national accreditation. These include: the accreditation scheme must be independently administered and accountable to the public, and the profession and must make decisions transparently and openly. This would be consistent with world's best practice, as acknowledged by Professions Australia, with the adoption of the WHO and World Federation for Medical Education guidelines for standards and development for accreditation processes; the need for clear recognition of the appropriateness of professionals working as the national board empowered to set the standards for training of members of the profession to conduct the work that they are qualified and empowered to complete free from interference from those persons not suitably qualified to do so; and concerns that the ministerial council has a reserve power over the standards that we believe may have a substantial negative impact on workforce numbers. This power, if used, may change standards, which may prove incompatible with the objectives of protecting and improving public health and safety.

The handling of complaints is of concern to us. The APodC has concerns that the introduction of the new position of the public interest assessor will unduly 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. Finally, we also have a concern regarding specialist accreditation and the lack of recognition for it in the new bill. I will hand over to Mr Lazzarini to speak on that.

Mr Lazzarini—Our gravest concern is that of specialist recognition—or the specialist register, as it is currently constituted in bill B. The APodC believes 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. In our January 2009 submission, there were two postgraduate specialist areas of practice—namely, podiatric surgery, with the specialists having attained the qualification of Fellow of the Australasian College of Podiatric Surgeons—and Dr Mark Gilheany will enlighten you about the podiatric surgery specialty later—and sports podiatry, with specialists having attained the qualification of Fellow of the Australasia Academy of Podiatric Sports Medicine. Both specialists have extensive postgraduate requirements and, for example, are recognised by the New South Wales Podiatrists Registration Board as specialist areas.

Since our submission in January 2009 the University of Western Australia are now providing a suite of innovative postgraduate courses through their podiatric medicine unit. These programs include doctor of podiatric medicine and doctor of clinical podiatry, with graduates legislated by

the Western Australian government to be eligible to apply to the Podiatrists Registration Board of Western Australia for recognition on the specialist register in Western Australia as podiatric physicians or podiatric surgeons. In addition, two areas of need within podiatry practice have also been undergoing extensive development towards recognition as specialised areas of practice, those being the high risk or diabetic foot, and paediatrics—although we do recognise that both areas still require considerable resourcing to meet specialist status.

APodC agreed with the original intent for specialist endorsement as outlined in the January 2009 consultation paper ‘Proposed arrangements for specialists within the National Registration and Accreditation Scheme for Health Professions’. This 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 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, as the January 2009 consultation paper also stated:

For the purposes of transition, from 1 July 2010, initial registration of specialists in any profession will be by an endorsement on the public register subject to (a) above. 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.

Does this mean that all specialist podiatric surgeons in Australia will only be able to practise general podiatry from 1 July 2010 until the national board has negotiated all of the relevant accreditation processes for this longstanding specialist group of health practitioners to be reinstated as specialists? We believe there is irrefutable evidence to see the re-inclusion of the podiatry profession as the third profession immediately eligible on 1 July 2010 for a specialist register, as podiatry already has specialist registers or similar on most state podiatry registration boards.

On that note, I would like to hand you over to Dr Mark Gilheany, the President of the Australasian College of Podiatric Surgeons, to give you more background on the establishment of the podiatric surgeon specialty.

Dr Gilheany—The Australasian College of Podiatric Surgeons is broadly in support of all the proposals that have been put forward in terms of national registration. The impetus for presenting to this committee is essentially what is seen as change to the notion of specialisation, and also some perceived angst coming from other organisations in terms of specialist titles that are coming forward. I have a five-page document here which I am not proposing to read; rather, I will pull out two or three of the salient points.

CHAIR—Do you want to table that?

Dr Gilheany—I am more than happy to table this full document later on.

CHAIR—That would be very useful. Thank you.

Dr Gilheany—In terms of salient points, for those that are not backgrounded in the notion of podiatric surgeons, podiatric surgeons are a specialist branch of the podiatry profession, performing reconstructive surgery on bones and joints of the foot and ankle, for over 30 years in

an environment in health policy which is really quite medico-centric and discriminatory in terms of access, efficiency and the economics of health care. The ACPS is a peak body for the training and accreditation of podiatric surgeons in Australia. It is a national organisation. It has been functioning since 1978. It liaises with the state and territory registration boards and has been accredited and affiliated with all available accrediting agencies through that time. Podiatric surgeons and the ACPS are recognised through several instruments of federal legislation and also instruments in state legislation. The standards of care as per podiatric surgery are recognised by all of those organisations, and to further that there is full legislative recognition of specialist status within South Australia and Western Australia existing already.

We also have a robust program of ongoing accreditation in addition to a role in surgical education. This has been acknowledged by all of the above bodies, including international peer groups such as the American College of Foot and Ankle Surgeons and the English Faculty of Podiatric Surgery. This currently standing specialist recognition provides significant protection to the public through identification and regulation of practitioners. Podiatric surgery is regulated and only performed by podiatrists with a combination of postgraduate university based education and specialist college based clinical education, with ongoing maintenance of standards through a structured accreditation program.

When the draft bill was being discussed there were two discussion papers released, the first one in September 2008 and the second one in January 2009. In both of those discussion papers the specialisation of podiatric surgery was listed within the podiatry profession—that is, medicine, dentistry and podiatry with specialisation were listed. In both of those papers there were no amendments or suggested notes attached in the discussion. It was quite perplexing and a little bit surprising to see that, when the draft bill came out, the specialisation of podiatric surgery was completely removed without any direct approach to the professional of podiatry and/or podiatric surgeons to question why this might be the case. Hence we are sitting here saying we have a raft of salient points in terms of history, regulation, recognition and education that suggest that we really already exist as a specialisation. To remove that specialisation from us at the moment is not in the public interest. It potentially would put the public at risk.

I sat before a Senate committee some years ago on the back of some legislative change. The parliament of this country said: we believe that podiatric surgery should be included in the Health Insurance Act to increase efficiency and competition in the surgical marketplace. It was a very strong and very valid push. The truth is that, in the years that have passed since then, that has not presented itself as effectively as it should have. There are still very many barriers, as I am sure senators are aware, to reform in the health sector. Podiatric surgery and podiatry in general face these barriers still. To take away our specialisation really reinforces the barriers. Whilst we are recognised as specialists at the moment, we are trying to contribute to the health sector. Take that away from us and we fall backwards. That is against the spirit of the IGA in my view. It is just not right.

I would ask as an aside that senators give consideration to the fact that podiatric surgeons have been before Senate committees in the past saying we need to improve access for the public of this country to help with elective waiting lists and a whole range of other major health issues. It needs to be brought up again. We have put letters and proposals before the health minister, we have economic reports now in place and we would encourage senators to actually reference

those documents. If you wish, we can also supply those documents, which talk about the economic impact of our services and the sorts of things that need to be done.

CHAIR—I would have been surprised if you had not put that on the record. You have been raising that for many years.

Dr Gilheany—The major action that, as a profession, we are bringing to you is to say that we strongly believe that the draft legislation should be amended to list podiatry as the third profession with specialisation, podiatric surgery, effective immediately. 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.

The last thing to bat on and then I will be happy to take whatever questions are forthcoming is the issue of titles. We have noted that there are some sectors of the health lobby that are getting particularly anxious about the use of titles, such as surgeon and doctor. There is a lot happening in the popular press and I am sure that this committee will be lambasted by some of these notions as well. I would like to put to the committee that the ACPS and the podiatry profession feel that the legislation, bill B, as it stands is entirely appropriate in that regard. It would be entirely inappropriate to again strip things back.

I function as a surgeon. That is what I do, all day, every day. To say that I should not call myself a surgeon is just bizarre. It is what the public understands, it is what internationally is understood, it is what the legislation says. It is just nonsensical. Terms like ‘doctor’, what is a doctor? A doctor has a PhD. What is a medical doctor? A medical doctor is somebody who went to university, did some academic training and then some clinical training and they provide health services. They provide health services, surgically, pharmacologically and physically. What is a podiatrist? Somebody who went to university, did clinical training, is a primary contact practitioner and provides health services, surgically, physically and pharmacologically. Similar things can be said for many, many health practitioners. There is no basis for the rhetoric that has been raised in terms of public protection and for some of the other notions that have been raised by some of the lobby groups in this regard. I think that in that sense the Senate should support the existing provisions of bill B.

CHAIR—Dr Whicker, do you have anything to add at this stage?

Dr Whicker—No, thank you.

Senator HUMPHRIES—Thank you for the evidence this morning. Before I come to this question that you have raised about the non-registration of podiatric surgery, your submission was presumably given to us before the new version of bill B had come out. Is there anything in your submission that you wanted to modify as a result of the final version of bill B?

Dr Gilheany—APodC will be resubmitting based on the latest draft for bill B. Within that submission these issues that I have just raised will be included.

Senator HUMPHRIES—Apart from those issues, are there other issues that you are going to raise? You say in your original submission that you are concerned about accreditation, you talk about the possible opposing interests of the ministerial council and the evidence based standards and accreditation functions agreed to by profession specific national boards. Is that still an issue or has that been fixed by bill B?

Dr Whicker—That is still an issue and we have reinforced that in the initial discussion points this morning.

Senator HUMPHRIES—All right. So that is still a concern and you are also concerned I see about the information that is collected by the new national board and the way in which that aligns with privacy considerations. Is that still a concern in the present version of bill B?

Dr Whicker—That is correct.

Senator HUMPHRIES—On this question of national registration of podiatric surgery, what is the situation at the moment with respect to state registration? Are podiatric surgeons registered in each state as surgeons at the moment?

Dr Gilheany—Yes.

Senator HUMPHRIES—And the territories as well?

Dr Gilheany—The podiatry profession is somewhat unique in terms of the 10 professions under the national scheme in that podiatry is not registered in the Northern Territory because I believe there are two podiatrists in the Northern Territory. To practise in the Northern Territory you need to be registered as a podiatrist. There is in fact a podiatric surgeon who is providing services now in the Northern Territory and that podiatric surgeon was allowed hospital admission privileges and surgical privileges on the basis that the individual is a registered specialist podiatric surgeon in South Australia. He would not have been given surgical and hospital privileges in the Northern Territory if that were not the case.

Senator HUMPHRIES—You said that in the first two versions of the consultation paper podiatric surgeons were listed as separate areas of specialty but in the third and final versions it does not appear. You said you had no feedback as to why that listing had changed.

Mr Brown—At no stage has it been explained to us why that has been removed or any evidence given as to why that would be appropriate.

Senator HUMPHRIES—Has APodC been involved in any professional groups that have worked around the development of the papers?

Mr Brown—Yes.

Senator HUMPHRIES—And those issues have not been ventilated in there?

Mr Brown—No.

Dr Gilheany—The issue has been raised at one or two of the forums that are roaming the country. The suggestion at the moment is that podiatric surgery was removed because it was not perceived to have a fully functioning Australian Medical Council style of accreditation across the country, but that was never brought to the podiatric surgeons nor the podiatry profession before that decision was taken. We would argue vigorously that we do in fact have a structure of accreditation which is very similar and mimics AMC style accreditation but we are a different profession. The AMC will not accredit us, because we are not medical practitioners.

Senator HUMPHRIES—So who was raising the point about not having the same style of accreditation?

Dr Gilheany—This has been presented by members of Dr Morauta's team.

Senator BOYCE—Does the Australasian College of Surgeons support your wish to be seen as medical specialists?

Dr Gilheany—We are not looking to be seen as medical specialists; we are looking to be seen as podiatric specialists. The royal college of surgeons does not support the activities of podiatric surgeons in any shape or form, as they are on record as not supporting terribly much in terms of alternate providers of services.

Senator HUMPHRIES—When you say 'they do not support', you do not mean they are hostile towards you, do you? They just do not cover any of your activities in their work.

CHAIR—I think it could be the other one.

Senator HUMPHRIES—I have opened a can of worms here.

Dr Gilheany—There is a can of worms. There has been hostility. I have personally been the subject of hostility from the royal college of surgeons in some areas. The Australasian College of Podiatric Surgeons has on numerous occasions written to the royal college of surgeons saying that we would like to work cooperatively with you if we could, and we get fairly short shrift. That is okay; we understand that we are a different profession. We would like to work cooperatively but, if you erode further where we are at, it will make it very difficult for us to work cooperatively.

Senator HUMPHRIES—When you said that Dr Morauta's team raised these issues, they were raising them because they were being raised in consultations by presumably—

Dr Gilheany—Yes. We have asked: 'Why is it that I have a piece of paper here that says we are included in a specialist register in bill B and in the column that says "proposed amendments or additions" there is a big "NONE" written and then bill B comes out and we have been omitted?' In the forum we raised our hand and asked why this occurred.

Senator HUMPHRIES—Can you explain again what the actual consequence of non-listing is though? It does not prevent a podiatric surgeon practising podiatry.

Dr Gilheany—No.

Senator HUMPHRIES—Does it prevent them from conducting surgery on a foot?

Dr Gilheany—I cannot answer that. I do not believe that it would. I cannot see that it should or that it would, but it creates an environment of more uncertainty. Surgery is a dangerous practice. If the new national board does not have the ability to identify those podiatrists who have training and are taking part in ongoing collegiate activity for peer review, standards review, ongoing education, then the national board is going to be nervous about allowing those podiatrists to work, because they cannot protect the public properly. It is about public protection. The real issue here is: we have podiatrists in this country who are recognised specialists and are acknowledged by registration boards around the country, and that provides protection and reassurance to the public; take that away and, to some extent, protection of the public is compromised.

Senator HUMPHRIES—I can just imagine what Dr Morauta will say when she comes here tomorrow and we ask her to defend that decision. I assume she will say: ‘Podiatric surgeons will still be registered as podiatrists. They will still be protected by the register in that sense. They can still do their surgery. They might not have the status of separate registration, but they are still there doing their job.’ What is your response to that?

Dr Gilheany—My response to that is that the national board will have difficulty determining which podiatrists can perform surgery and which cannot.

Senator HUMPHRIES—Why do they need to do that, though, if they are all registered as podiatrists?

Dr Gilheany—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. Dr Morauta may reassure you that that will not change, but we do not know. You are putting an extra burden on the new national board to try and regulate and control behaviour. It will be more difficult for them to do it and they may not have a framework. 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 there and, rather than pulling apart what is already there, let us build on it, let us improve it. 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.

Senator HUMPHRIES—I have one more question. I am trying to work out what the equivalent arrangement would be in other professional groups. I think you can get such a thing as ophthalmic surgery, can’t you—surgery on the eyes?

Dr Gilheany—Oddly enough—and this is a core issue—in health, to my knowledge, it is only podiatry that has the ability to perform surgery, although I completely appreciate and recognise that there are now nurse surgeons in many countries. I believe—but I am not a hundred per cent sure yet—that nurses are working surgically in Australia. Certainly they are in the UK. But traditionally it really has only been medicine, dentistry and podiatry for which surgery is included as a core activity and has always been included. I think that appropriately reflects the

draft legislation, the previous draft legislation and the discussion paper, which included medicine, dentistry and podiatry.

Senator FURNER—Are you in the same position as other medical practitioners and providers of health, where we have seen in some circumstances a need for overseas practitioners to enter Australia to assist with the skills shortages? Are there any implications with accreditation and training of those practitioners? How will that impact on the proposals that are before us?

Mr Lazzarini—We do overseas accreditation now as part of the APodC. We have had meetings with the Department of Education, Employment and Workplace Relations, who are very happy with that accreditation, and the overseas training applicants who are coming through. We assess about 40 or 50 a year basically. So we do not see it as being an issue from bill B at this stage.

Senator FURNER—So their standards are on par with the training and accreditation that we have in this country.

Mr Brown—We have several overseas teaching institutions that have similar arrangements to the Australasian Podiatry Council, so we recognise those organisations. Whilst there are some that are not up to scratch, there are quite a few coming through. We would always like more. In fact, we would encourage it.

Senator FURNER—Are you able to comment on the complaints management and disciplinary process that is proposed in the bill and how that might affect your profession?

Mr Brown—That was raised in our initial statement, which talked about complaints handling. We are concerned about the public interest assessor being separate. Senators, to be honest with you, I am not particularly nervous coming in front of you, but were you seven of my peers I would be completely concerned about sitting in front of you. I believe that sitting in front of my peers and being judged as to whether or not a complaint is necessary or frivolous is much more likely to affect my decision of practice. They are the most powerful group that can judge whether or not that complaint is worth while. They will pass judgement and make an assessment on that much more clearly than a bureaucrat who may not have any podiatric experience whatsoever or any understanding of how podiatry works, as the public interest assessor would most likely not have.

Dr Gilheany—There have been concerns raised that, whatever complaints process is put in place, it needs to also provide timely outcomes at a reasonable cost, in terms of natural justice. If you have too many added layers of bureaucracy involved in the complaints process you may extend time frames, which disadvantages people, and you may cause increased cost. The complaints process, in whatever form it is eventually put in place, needs to be actively reviewed so that there is some genuine follow-up to find out whether or not it is costing the professions more money and resulting in long delays in getting into VCAT or other appeals processes and whether or not issues have been resolved in a timely fashion.

Senator BOYCE—To get back to the APodC submission, you have said that you believe:

Any accreditation scheme must be independently administered, accountable to the public and the profession, and must make decisions transparently and openly.

Can you give me some suggestions from your council on how this might be achieved and on changes that need to be made?

Mr Brown—I suppose it is about the concern that the ministerial council can overrule the national board. We believe that the ministerial council oversight is not as necessary.

Senator BOYCE—So you would say that the board should have full control. What about the transparency and openness of decision making—how would you see that being achieved?

Dr Gilheany—Are we talking about the whole nature of accreditation in professions or are we talking about processes of the national board?

Senator BOYCE—I am talking about the section in the submission from APodC which says:

Any accreditation scheme—

presumably meaning the accreditation part of the national registration accreditation scheme—

must be independently administered, accountable to the public ...

Dr Gilheany—In answer to that element—

Senator BOYCE—I am interested in what you would want changed to achieve that outcome.

Dr Gilheany—To achieve the outcome of true independence of accreditation?

Senator BOYCE—Independent administration, accountability to the public and the profession, and transparent and open decision making.

Mr Lazzarini—As per the submission, we would like the process to follow world's best practice, so World Health Organisation and World Federation for Medical Education guidelines. They state in their standards that the professional accreditation process should be divorced from the government. We understand the government's need to govern, but according to world's best practice—

Senator BOYCE—What aspects of that need to happen to change the linkages? Is it the linkages between the national boards and the ministerial council that concern you most?

Mr Brown—Yes.

Senator BOYCE—World's best practice is fine, but I am not going to go and look up a document on world's best practice. I need you to tell me what you want in this legislation for us to consider that.

Mr Brown—The separation of the ministerial council from the national board is what world's best practice is suggesting and that is what we are suggesting should happen. They should be divorced from each other and they should be separate from each other.

Senator BOYCE—That would achieve the objectives in your terms?

Mr Brown—Yes.

Senator BOYCE—In relation to transparency and openness of decision making, what needs to be changed?

Dr Whicker—If the first suggestion were enforced then that would not be a problem. As it is currently proposed, the issues around transparency and notification are that a decision may well be made without involving discussion with the profession or the accreditation body and notification will be made some time, which could well be at the tabling of the annual report.

Senator BOYCE—The fact that the decision making disappears into the mechanisms of the ministerial council is what most concerns you about that aspect?

Dr Whicker—That is correct.

Senator BOYCE—The other question I have was regarding your comments on the collection and use of information and the concerns you have about the use of de-identified data et cetera. Could you give me an example of the problems that might arise with the silence on this topic within the legislation?

Dr Whicker—APodC initially tabled this because part of the problem is that in the transition everybody is unsure as to the level of the expertise of the staff and there are several major changes happening in parallel with this legislation as well as inexperience in staff and other areas of the e-health agenda. The council thinks there is a need to be astute about the use of de-identified data and maintaining that to ensure that members of the profession and/or their clients and patients are kept in that de-identified area. That is common practice within other areas of Medicare Australia, formerly HIC et cetera. As there is so much change taking place we were concerned that some of these issues may not be picked up and taken to the standard that is currently accepted.

Senator BOYCE—Does the bill need strengthening in that area from your viewpoint?

Dr Whicker—At the moment I would say no because of the concern that we have not seen the exposure draft when we prepared this.

CHAIR—I have a couple of questions in term of process. It surprises me that these issues, particularly those as to the surgery aspect, have not been picked up in the consultation process. I want to get clearly on the record—and I know Senator Humphries went close to it in his questions—that you have been involved in the national consultations and they have had face-to-face and email interaction. When you raised the particular issue about the surgical provision—and I know you have been following it for many years—what was the response that you had back from Dr Morauta's team?

Dr Gilheany—The first we heard that we were removed from the legislation was via the communique of 8 May.

CHAIR—Which was just sent out to everybody and it was not specifically to you?

Dr Gilheany—Yes.

CHAIR—So it was in the general communique of 8 May?

Dr Gilheany—Yes.

CHAIR—Amongst a whole range of other changes that happened?

Dr Gilheany—Yes, amongst a whole range of other changes. It was reading the communique that alerted us to the fact that genuinely we had been removed.

CHAIR—I remember reading that communique and I did not see it—

Dr Gilheany—We were just not mentioned.

CHAIR—It was just by omission?

Dr Gilheany—By omission.

CHAIR—And your professional group or the people who had been involved in the consultation processes were not approached personally?

Dr Gilheany—No formal approach but there were one or two informal discussions that I had in picking the omission up. Since that time wherever possible at the national forums we have raised the issue or the issue has been raised and the response we have had is as I have indicated earlier, that the official reason—and this is a verbal response—is podiatric surgery was not seen as having a strong enough national accreditation scheme. I am having to struggle with the words because when you have these conversations with people various things are thrown at you and I have nothing on paper from—

CHAIR—Nothing at all?

Dr Gilheany—Nothing. So I do not have anything on paper. The Australasian College of Podiatric Surgeons are preparing a submission to go to back to the next round. In that submission we will be arguing strongly that we should be placed back in the legislation. We will be arguing strongly, as I have already done to the committee, that we have a very powerful and strong accreditation and it is not in the public interest to remove us at this point in time. I have to admit that I have not directly sought to write a letter to that office at this point. There did not seem to be terribly much point in doing so. We realise we have to put a submission into the legislative review.

CHAIR—The other issue is one that Senator Boyce was addressing. It goes to the issue of transparency. In your opening statement, Mr Brown, you actually said you wanted transparency.

Whilst you have identified the issue about the linkage with the ministerial council—and I take that point and that is part of a general discussion; people have raised that—why do you think there is any danger of the proposed system being less transparent than what you have already got? Transparency is a fairly critical term. From the outside point of view, the system now is fairly in house in terms of how it goes. What are your concerns about proposed bill B that actually lead you to think there could be any reduction in transparency?

Mr Brown—If I were to answer that it would be, broadly speaking, a fear of the unknown. We really do not know what the ministerial council would do. If that were to be removed then that would reduce, as we have explained to Senator Boyce, some of that concern—if that answers your question.

CHAIR—Yes. I it was just wanting to see about that, because in terms of the issue the link with the ministerial council and the independence aspect were covered but I was just picking up the statement about transparency. So you do not know whether it is going to be so or not?

Mr Brown—Yes. We are concerned that that will be lost.

CHAIR—Sure, and that is perfectly fine. I was just concerned to know whether there was an element there that you were aware of. Is there anything else that you would like to put on record? Certainly you can get back in contact, and I know you are going through the Morauta process as well. Is there anything that we have not picked up in our questioning?

Mr Brown—The answer ought to be placed on record—and you asked to ensure that it was placed on record—that we attended the professional reference group and all of the public forums and that we have been part of the forum for accrediting councils.

CHAIR—I am sure you would have been.

Mr Brown—Yes, just so it is on record that we have in fact attended all the necessary forums and all the necessary meetings at a national level and sent representation to all of the state and territory organisations and that we have had our ears and eyes open.

Mr Lazzarini—I would quickly add this in terms of some of the questions from Senator Humphries in terms of what Dr Morauta might say about the specialist register. Part 2, clause 12 has that any health group approved by the ministerial council, other than medical and dental and on the recommendation of the national board, could be established as a specialty register. I guess she would say that therefore they can go through the process come 1 July 2010. We would ask 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. Those are some of the answers that I imagine you would get from Dr Louise Morauta tomorrow, to suggest that there is an open process to get the specialist register up again. But 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. I just want to bring that to you attention.

CHAIR—And the only state where it has not gone is the Northern Territory?

Mr Lazzarini—Sorry?

CHAIR—The only state where it has not happened is the Northern Territory?

Dr Gilheany—Yes.

CHAIR—It just puts on record that it has gone through everywhere except in the NT.

Mr Brown—In the Northern Territory you register. You have be to registered in other states.

CHAIR—And for that to be a reason for negativity is interesting in itself. Thank you very much. If there is anything that you do think you would like to get to us after you have finished—and sometimes that is when these things come to you—just been in contact with the secretariat. Thank you all.

[9.53 am]

BEEVER, Mr John, National Manager, Government Affairs, Optometrists Association Australia

CHAKMAN, Mr Joseph, Chief Executive Officer, Optometrists Association Australia

HARRIS, Mr Andrew Kirk, President, Optometrists Association Australia

CHAIR—Good morning and welcome. Information on parliamentary privilege and the protection of witnesses is available. The committee has your submission. I note it is an April one so there could well be things that you are wishing to add since that last round of information has gone out. I invite any or all of you to make an opening statement if you would like to do so, and then we will go to questions.

Mr Harris—I want to thank the committee for the opportunity to talk about national registration and accreditation. For some context, the Optometrists Association of Australia has 4,000 members who comprise about 95 per cent of registered optometrists. They perform some 5½ million eye services per year. They prescribe ocular therapeutic drugs, supply contact lenses and spectacles, detect eye disease, treat some eye disease, refer patients to ophthalmologists and so on.

As we have stated in the submission, optometry's position on national registration and accreditation is positive. We think it could be improved with some changes. As we say in our submission, the initiative is a chance to bring together the best practice from around the country into a unified system served by the best systems available. You have probably heard this but we will say it again. While supporting this initiative from the outset, optometry has argued that the design needed improvement, and there were two main areas of concern. One was the independence of the accreditation process, which we can go into further. The second was the ability of the boards to control their own funds and resources.

We note that, with regard to the main ministerial council, there was an announcement that the proposed arrangements for accreditation of health professions' education would be changed to ensure its independence from governments and that the change was largely adopted in the national draft law released last month. We believe accreditation is now almost independent and we can propose how we think it should be made fully so.

CHAIR—Even more independent, Mr Harris?

Mr Harris—Exactly. The draft bill is less clear on whether the national boards will have control of the resources. We think that, in order to fulfil their statutory regulations, they will do so more effectively if they are not putting their hand out to a central agency—and we will talk further on that matter.

Obviously, the attraction of national registration is, in part, the uniformity of practise across state and territory jurisdictions. It is worth flagging that S4 medicines that optometrists prescribe

will still be controlled under the state poisons acts. We trust the uniform approach will be encouraged to ensure that there is a consistent drug list across the nation. We also noted after the draft legislation came out that optometry was surprised by the reference to orthoptists within it. We do not think that this makes a lot of sense, and we will outline why we think that. But, as I said, in general, optometry supports the new scheme, and we think it can be further refined.

CHAIR—Mr Beever, do you want to add something?

Mr Beever—We would like to address the points that we raised in the submission and then go on to some more optometry specific points, including the ones just flagged. As Andrew has just told you, we are very pleased with the changes that were announced by the ministerial council on 8 May. As you have seen from our April submission, this was a concern for optometry, along with all the other professions who have variously made submissions over the last couple of years.

We see the 8 May changes to accreditation as being a great step in the right direction but not quite there yet. It is almost independent now. We think with some further minor changes, modest changes, we will get what I think all the professions would be looking for—and certainly what optometry is looking for. As we say in our submission, we believe that ministers should have a reserve power to intervene where the system does not perform, and that would go also to accreditation. But we see that as a reserve power to be exercised as a last resort and only under certain limitations.

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. We can elaborate on that point now or under questioning, if you wish.

CHAIR—It is a key issue, so if you would like to move on to that point we will ask questions around that. That would seem sensible.

Mr Chakman—Independence of accreditation seems to be crucial to public safety here, if you want to maintain standards. I imagine you have heard all the arguments; we do not need to repeat those. 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, in our case, the medical council, the physiotherapy council—I am not sure about others—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. In our case we have the Optometry Council of Australia and New Zealand. More than half are actually representatives of the profession and slightly half are nominees of the schools of optometry and registration boards. We regard them completely as nominees, not as representatives. We do not instruct them, we do not get reports back from them. We just provide the names of people when their term of office comes up and they get appointed to the authority. We get no feedback and we have no control over those people. We believe that gives a great deal of independence to the authority.

As John mentioned before, the government need to have some ultimate oversight of the arrangements and should only come in when they see a failure of the system. The problem with the proposed legislation is that it does not sufficiently explain what those limitations should be. We have general ideas but no specifics to suggest. Essentially, that is our suggestion for the accreditation process.

CHAIR—The way you describe how your professional body now operates, why would not the ministerial council operate in exactly the same way? The way you explained the way the profession operates now is you nominate the people on it but, in terms of the relationship from then on, you do not intrude, you do not control, you do not dismiss. Why is it okay for the profession to nominate, as indeed my reading of the legislation indicates, that that would be the way the ministerial council would nominate?

Mr Chakman—We have no guarantees that would be the way it would operate.

CHAIR—That is where you are saying if you had some of those roles defined or listed—

Mr Chakman—If the composition of the accreditation authority was specified, that would certainly alleviate our concerns quite a deal. We think it would be better if the relevant authorities involved—the boards, the profession and the schools of optometry—made the decisions ultimately, because we feel that they are in a better position to be able to make wise decisions. They know the people involved, they know the issues involved.

CHAIR—It is a threshold point.

Mr Chakman—Yes. It is not something we go to the barricades on.

Senator HUMPHRIES—Just following on from that question, in bill B you used the words, ‘The ministerial council appointed the accreditation body.’ My impression was that they were going to nominate the accreditation body, as in they had the power to take an existing accreditation arrangement and say, ‘That is the accreditation arrangement for this particular area.’ In those circumstances, who else could they nominate in the case of optometry?

Mr Chakman—In the initial stages that is what our understanding is, too, but once the term of office of those people appointed expires there is no clear mechanism for what will happen subsequently.

Senator HUMPHRIES—Are we talking about the accreditation body here or the optometry board?

Mr Chakman—The accreditation body.

Senator HUMPHRIES—So you are saying that bill B provides, effectively, for the legislation to constitute the accreditation body for optometry?

Mr Chakman—And for all the other professions.

Senator HUMPHRIES—So ministers themselves have the power to nominate who will be on those various accreditation bodies in each occupation?

Mr Chakman—That is my understanding. That is our understanding.

Senator HUMPHRIES—Okay. Well, I will have to clarify my understanding. That was not my impression of what was in bill B.

Mr Chakman—Not in the first instance. Our understanding is that, when the scheme comes into operation, at first the existing authorities will take over the job because it is just too difficult to do it any other way. But, once they are established and running under the new program and the terms of office of the existing nominees runs out, how will the next set be appointed?

Senator HUMPHRIES—It was my impression that they would be appointed in the same way they had previously been appointed—effectively by the professional groups. But that is not the case; there is a certain significant difference.

Mr Chakman—It is uncertain to us.

Senator HUMPHRIES—We will check that out and find out what the story is.

CHAIR—We anticipate that people from the various agencies are watching this, or at least will be following up very closely, so they can make sure that is a question added to what we will be asking them. In terms of the consultation process, has this been a point that people have had information on? Have you raised this? I know your profession has been deeply involved in all the appropriate consultative mechanisms. Has this point been raised in the consultative mechanisms and has there been a response?

Mr Chakman—Certainly the point that we are not confident about the processes being raised has been. We have not actually offered proposals on this issue.

CHAIR—It has not been part of that discussion yet?

Mr Chakman—No, it is going to be but it has not been yet.

Mr Beaver—No, the generic concern about independence of accreditation has been raised repeatedly—

CHAIR—From day one.

Mr Beaver—but not the specific.

Senator HUMPHRIES—I want to come to the question about how you run the boards that govern the operation of the particular registration processes. You say:

The current design has AHPRA holding all scheme funds and controlling all resources in NRAS. We believe this will give AHPRA effective control of both registration and accreditation which will amount to Government interference in an area in which it has little expertise and is properly the domain of the professions.

If that still your concern about the way that the boards are funded?

Mr Chakman—It has been lessened a little bit. There is only one clause in the legislation that suggests that the boards have more power over their money than we previously thought, and it is unclear. John probably understands this better than I.

Mr Beaver—What has emerged since we put in our last submission has given some comfort in this area. We have maintained that the boards in effect should control all of their own resources. The boards in effect raise the funds to run the new scheme, and we have taken the view that for simplicity and clear lines of communication and control the boards should control the disbursement of those. What is new since our last submission is that there will be a health professions agreement, which will be negotiated between the agency and each of the boards concerning the budgets for the agency service delivery and the boards' ongoing requirements, including the requirements for accreditation. That was always foreshadowed, but what came out in bill B was section 2506(3). A subpart of that seems to suggest that boards may control the use of any funds left over in their subaccount with the agency.

CHAIR—Once the agency has been effectively funded?

Mr Beaver—Once the agency has been funded.

CHAIR—But anything after that, should there be money—

Mr Beaver—Precisely, and our concern here is simply to clarify that our understanding is correct. If it does have funds left over after providing for the ongoing arrangements for the agency and anticipated requirements of accreditation and the board, the board itself may commit those remaining funds to purposes which the board determines are within the scope of the legislation without having to ask the agency's permission or approval. This is grounded in experience.

Mr Chakman—We also have a bit of concern about the budgetary process. The budget has to be negotiated with the agency. If the board wants something and the agency does not want something, what happens in the end is that although there is a process, it is not one that fills us with great confidence. If I could give you an example of what actually has happened in the past, in Australia most of the optometry boards actually have full control of their own resources. In two places, New South Wales and the Northern Territory, they do not. The money goes into effectively a consolidated pool of some sort and if the board wants to spend any money, it has to ask the agency for it.

We had the situation many years ago where we did not have an accreditation authority for optometry and the whole profession got together. To get such concordance is really remarkable, the schools of optometry, the registration boards, and the profession itself all got together and agreed that we should set up an accreditation authority. We drafted the constitution, had everything organised, even the New South Wales and the Northern Territory boards agreed to it. In fact the New South Wales people on the board were leaders in the process. When the time came the accreditation authority had to be funded so each of us put in and said we will contribute money and resources on the following basis. The New South Wales people went back and asked

for some money to put in their share and their equivalent of APRA said, 'Sorry, we're not going to give you any money.'

We ran the Optometry Council for many years, I think it must have been 10 years, with the others making disproportionate contributions and the New South Wales government getting a substantial benefit from the situation. Their board had no powers to spend the money that it had collected from its registrants. We do not want that situation to arise. We can see that there are good things, things in the public interest, such as the accreditation authority that the board may choose to do but, if it cannot get agreement from APRA, it will not be able to do them.

Senator HUMPHRIES—There is a sort of a spectrum here though isn't there? On the one hand, you could have the boards basically just looking after their work of registering, accrediting and so on and leaving all the other details to APRA or you could have complete independence on the part of the boards where they control their funds, they determine how much the fee should be so that they can cover their costs and so on. The more you get to that end of the spectrum though the more you need to populate your board with people with appropriate expertise in those sorts of things. Some of these boards would be responsible for millions of dollars worth of registration fees and associated amounts I would have thought. You would start to need financial advisers and lawyers on the board to run those sorts of things.

Mr Chakman—I do not think so. They could still get that advice from APRA. What they want to know is what they can spend their money on really. It is not as though they can spend any more money than they have.

Senator HUMPHRIES—With respect, that is another issue. Being able to spend their surplus money is a good thing, but they also need to manage the dollars that they have. I was health minister in the ACT and the various boards we had focused on the work of registration and disciplinary matters with respect to people in those particular occupations but the running of the financial side of the operation was basically left to public servants who reported to me as the minister.

Mr Chakman—If you were to talk about wise investment of the money and all of those sorts of things, I would agree with you wholeheartedly. I do not think that is the business of the boards.

Senator HUMPHRIES—But it would be the business of the boards if you are suggesting there should be complete independence and the board should control all of those issues as well.

Mr Chakman—Okay, I will take it back a little bit from the extreme independence that I want. But it should have the authority to spend money on things that are directly related to board matters—that is, the things that it has been set up to do. If it has been set up to run programs to ensure safety and quality, it should be able to decide to spend money on those issues.

Senator HUMPHRIES—Were you saying, Mr Beaver, that you thought you had the independence to spend the surplus funds under the provisions of bill B?

Mr Beaver—We believe so. Section 256(3) talks about the funds from a board subaccount, managed by the agency, being used both for the purpose of the agreed budget and as 'otherwise

approved by the board'. Our understanding is that a board may choose to do something over and above what is in the budget.

Mr Chakman—But we are reliant on those half-a-dozen words that say: and other matters as 'approved by the board'.

CHAIR—So you are seeking reassurance.

Mr Chakman—Yes.

CHAIR—You are seeking more clarity.

Mr Beever—Correct.

Senator HUMPHRIES—In your original submission, you seemed to suggest that the idea of APRA holding scheme funds and so on and negotiating resourcing for the boards is a problem with the structure of the NRAS. But you are slightly more comfortable with that arrangement now than you were before.

Mr Beever—We are so now. We still like the simplicity and elegance of our proposal, but ministers were not persuaded.

Senator HUMPHRIES—Indeed. They seem to be like that sometimes.

CHAIR—Particularly those health ministers!

Senator HUMPHRIES—Especially the health ministers. These days that is true!

Senator WILLIAMS—Not in the old days!

Senator HUMPHRIES—Of course. Under 'Consumer Complaints' you say:

Optometry believes such complaints handling agencies should remain the responsibility of state and territory governments and not be part of NRAS.

I understand under the new version of bill B a certain amount of autonomy is restored to the state and territory boards to run those complaint mechanisms. Are you happy with those arrangements? Do you think that they will work as proposed now?

Mr Chakman—We have two sets of arrangements now, from the looks of it. We have one in New South Wales and one for the rest of the country. That complaints-handling mechanism in New South Wales will be different.

Senator HUMPHRIES—They will be different under bill B?

Mr Chakman—Yes.

Senator HUMPHRIES—In what way?

Mr Chakman—The HCCC in New South Wales will retain control of complaints made in New South Wales.

Senator HUMPHRIES—That is just in New South Wales, is it?

Mr Chakman—Each state could do so too, but our understanding is that only New South Wales has chosen to maintain its existing programs. In any event, we feel quite comfortable with the arrangements.

Mr Beaver—There is one nuance there: something new that came out with bill B was the public interest assessor. To put it simply, we understand it to be an office holder to ensure the system works in the public interest and not in the interest of any self-serving professions that might suborn the process. That public interest assessor is part of NRAS. We believe, as it 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.

Senator HUMPHRIES—Thank you for that.

Senator FURNER—Do you have any concerns about the proposed management and disciplinary processes of complaints?

Mr Chakman—I do not think we do. They seem fairly rational and reasonable. They are not so much different to what takes place at the moment in practice.

Senator FURNER—So you would not have an issue, for example, with someone being on a panel who has little or no experience in optometry understanding what the particular complaint may be?

Mr Chakman—I have a feeling that that can happen at the moment and that is not how it works. I suspect that people are quite sensible in making the decisions on who they put on panels to make sure they are experienced. We rely on the authorities to do that. They have to date in eight jurisdictions around Australia. I cannot imagine that that would change.

Senator FURNER—You say that it could happen at present. Has it ever happened?

Mr Chakman—We have so few complaints about optometrists that the answer I give you is meaningless.

Senator FURNER—Are you like other professions where there has been a need to inject overseas practitioners into your field at all? Also I would like to hear from you regarding any concerns about training or accreditation.

Mr Chakman—We have a fair number of overseas optometrists coming to Australia. The numbers are not huge but there is a constant stream. Optometry is not a profession that is

generally practised around the world. It is largely a profession of the English-speaking countries and increasingly so of Europe and South-East Asia. We have people coming from a limited number of countries at the moment. Our optometry council is responsible for conducting examinations according to competency standards that have been established for the profession. Local optometrists have to meet the standards on graduation and so do incoming people.

Senator BOYCE—Can you talk us through the involvement of the professions reference group in the discussions to date. I am interested in where the professions do not hold common ground.

Mr Beever—I chair the professions reference group. The professions reference group is an informal collection of the peak organisations representing the 10 professions initially involved.

Senator BOYCE—So you are not a professional group. Do you speak for the 10 organisations though when you discuss matters with COAG?

Mr Beever—We have rarely spoken as a group. It is a broad church. There are as many factions in the PRG as there are in political parties in this place. There are broad views. I have to stress that I do not speak on behalf of the other professions. I can say that over the two years or so that we have been working together as professional groups there has been convergence of views around the common concerns. Several professions have profession-specific concerns, such as the ones we have flagged that are specific to optometry, and each pursues its interests separately. There has been general consensus around the two issues of concern that we have talked about thus far, particularly accreditation. I think it is fair to say that all of the professions shared the concerns that you have heard about accreditation.

Senator BOYCE—And that concern particularly being that workforce pressures might cause governments to change or corrupt accreditation processes.

Mr Beever—I would say ‘intervene inappropriately’ in such processes.

Senator BOYCE—Well said.

Mr Beever—I think the nearest we had to a consensus view is that nine of the professions wrote to ministers early in May urging them to hear us on accreditation and hear us on the issue of control of resources. We were delighted shortly after to see that the ministers had heard and responded to us on accreditation and appeared to be responding to us on the control of resources issue. Beyond that letter of early May, I would not say there was necessarily a common view. Does that answer your question?

Senator BOYCE—Yes, thank you.

Senator WILLIAMS—Mr Chakman, you are saying that the national complaints commission should remain with the states and territories and not with the NRAS?

Mr Chakman—No. We are quite happy with it either way, in reality.

Senator WILLIAMS—I am saying that because in your submission—

Mr Chakman—There need to be some mechanisms for handling complaints on a local basis, because you do not want to have practitioners from Victoria going to the Northern Territory to have their complaints heard and things like that. There need to be local aspects to it. I suppose it comes back to the point that we have so few complaints against optometrists that I would not regard this as an area of superexpertise amongst us.

CHAIR—Mr Harris, you referred to a specific issue in your opening statement that was peculiar to your profession. I wonder whether you want to put that on record, because it is not in your submission. It was a term you used. I hesitate to try to say what it was.

Mr Harris—There were probably two specific issues. One was therapeutic drugs lists.

CHAIR—Yes, you went into that.

Mr Harris—The other one was the inclusion of orthoptists in bill B.

CHAIR—That is the one, yes.

Senator BOYCE—The inclusion of?

Mr Harris—Orthoptists.

Mr Chakman—When the original communique from COAG came out it specified that there would be restricted practice for optometrists in one area. When bill B came out we found that, in that restricted area of practice, another group had been introduced, which we think is contrary to the COAG intention and undermines the whole program. The situation is that 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.

It sounds a bit abstruse but we have had this issue investigated since the 1980s, when competition policy was first introduced. Every state was required to go through its legislation to deregulate as much as it could. Optometry had great portions of its activities deregulated, but that stayed in place. In most jurisdictions in Australia there have been subsequent reviews of that policy, and in every state and territory of Australia the governments have decided that it is such a public health issue that they want to retain it. Now we find that in bill B there is one clause that says orthoptists, who are practitioners largely working as assistants to ophthalmologists and in public health institutions, have been given an exclusion from that prohibition. We think it undermines the whole public health issue because they are not in the position of being able, for example, to exclude eye disease as the cause of a need for spectacles. To give you an example: someone with diabetes may have changes to their eyes that make them short-sighted. You can prescribe a pair of spectacles for them and that will solve the short-sightedness in the short term but it is not going to pick up their diabetes. That sort of thing is what we are talking about here.

Mr Harris—Even though Joe is not an optometrist, he has been correcting me in fact.

Mr Chakman—There are many other examples of that issue that we could raise. We have a lot of people in Australia who have lost their vision, and we do not want any more. That is basically what this argument is all about. Our time is running out, so I will cut down on the presentation. We are not arguing for restricting practices of other professions. They are justified in improving their position in the healthcare system. 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. It just seems to be a ridiculous sort of thing to do.

CHAIR—And this popped up in bill B?

Mr Chakman—Yes.

CHAIR—And it had not been in the other discussions that you had had?

Mr Chakman—There had been discussions about it, and we thought that we had come to some sort of understanding with Dr Morauta's group on how this would be handled, and when the bill came out we were quite shocked. What we suggest is just a removal of one clause from the bill. That would leave the board with authority to allow any group that they chose or any people that they chose to perform the prohibited act as the board decides rather than have any legislation.

CHAIR—Rather than have orthoptists mentioned specifically?

Mr Chakman—Yes.

CHAIR—It does seem odd that it has popped up. We will ask. Are you aware of any lobbying around the orthoptists' situation that has been going on? Certainly it has not come to us. Are you aware that there has been a lobbying process?

Mr Chakman—There has been interest. Several states have exclusions at the moment. One state that we know of has pushed pretty hard for this.

CHAIR—Which one is that?

Mr Chakman—Victoria.

CHAIR—This is a Victorian thing that they operate. Now the Victorian thing is in the national bill. Is that too simplistic?

Mr Chakman—That is right. Certainly the five other jurisdictions that have no mention of orthoptists in legislation are having new legislation upon them. I do not think that that is sensible.

CHAIR—That is one we have not heard before, so I just wanted to check. The one on drugs you actually spelt out. Was there anything else on that, Mr Harris? You spelt it out in your opening submission. Was there anything else you wanted to say about that?

Mr Harris—No, it was just more to put it on record.

CHAIR—Sure. Once again, that had not come up in the process so far.

Mr Harris—It seems that consistency of practice across states and territories makes a world of sense but then there is potentially a spanner in the works, so we thought we would let the committee know. At present we have a fairly consistent drug list across all the states and territories—other than Western Australia, where optometrists cannot prescribe at the moment. That leads to certain problems. You have graduates that do not wish to go across there because they cannot work to the full extent of their competence. The antiglaucoma medications are on the PBS list and yet because of local issues up in Queensland they are not able to be prescribed by optometrists.

Senator BOYCE—In Queensland.

Mr Harris—In Queensland.

CHAIR—But they can if you go to Tweed Heads.

Senator BOYCE—Some drugs can be.

Mr Harris—You can if you go south or west. It is really not within the national legislation to control that, but I thought we would make it noted.

CHAIR—It is an issue.

Mr Harris—Yes.

Mr Chakman—It becomes an issue under national registration because the national board actually has to some way take action against practitioners that may not adhere to the rules or something like that. While the poisons acts are local, any breach of them finishes up being addressed by the national board. The national board will have to have different rules for each state.

CHAIR—We are currently looking at another piece of legislation that is looking at the TGA role and the states poisons acts. We are between the two of them. We will ask Dr Morauta, anyway, when she comes.

Mr Harris—You could certainly get an issue where if you were in Albury Wodonga—I cannot remember which is on which side of the border—you could grab someone and say, ‘Okay you’ve got microbial keratitis, just come across the border and I’ll write you out a script for fluoroquinolone.’ You have this crazy situation at the moment. Obviously, this legislation at its practical level will hopefully sort some of that out.

CHAIR—Thank you very much. If there is anything that you think we need to know that you have not put on the record, please be in contact with us. That would be very useful.

Proceedings suspended from 10.35 am to 10.46 am

[10.46 am]

LITTLEFIELD, Professor Lyn, Executive Director, Australian Psychological Society

O’GORMAN, Professor John, Member of the APS College of Organisational Psychologists, Australian Psychological Society

STOKES, Mr David, Senior Manager, Professional Issues, Australian Psychological Society

CHAIR—I welcome representatives from the Australian Psychological Society and the College of Counselling and Organisational Psychologists. You all have information on parliamentary privilege and the protection of witnesses. You are very regular contributors to what we do and we very much value that. We have your submissions. I would invite any or all of you to make some opening comments and then we will go to questions.

Prof. Littlefield—I want to talk about the accreditation issues, protection of title and scopes of practice. David will talk about registration issues and John will talk about the non-health psychologists. In terms of accreditation this meets terms of reference c:

the effect of the scheme on standards of training and qualification of relevant health professionals;

We really want to focus on the independence of accreditation functions from government. Some of the most serious concerns, which the Australian Psychological Society has regarding the exposure draft of bill B, are around the failure to secure the independence of accreditation and training standards from interference by government.

The treatment of accreditation in the draft bill seems to reflect a retreat from the commitment given in the 8 May ministerial communique to ensure that decisions of the accreditation boards are independent. Clearly, the most important aspect of accreditation is the protection of standards of professional practice in the public interest which is poorly served by the provisions to do with accreditation in the draft bill. There are two key aspects to the accreditation provisions in the bill which are unacceptable. Firstly, 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. This concern is even more troubling given that bill B is silent on the matter of grounds on which the appointment of an accrediting entity might be made. That is recognised overseas, too, as you would well be aware, where accreditation is recommended as being separate from government.

The second issue is the reserve power of the ministerial council to interfere in the setting of accreditation standards, which is in clause 10(3) and (4), where the council believes a standard would have a substantive and negative impact on the recruitment and supply of health

practitioners to the workforce. These provisions in the draft bill again permit government interference in standards of training on the grounds of short-term political concerns such as workforce supply instead of the quality of professional services provided to the public.

The fear is that pressure to increase workforce or save costs may result in a decrease in the length of training required for registration, and specifically in the amount of practicum required, which could have a deleterious effect on public safety and the quality of services. Further, 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.

Australia is actually struggling with that to do with psychology. The minimum international standard is six years of university training, and in many cases that six years requires a doctorate. Our standard at the moment for registration—the base standard—is four years of university plus two. Some time ago, around 2000, both the Australian Psychological Society and all of the state and territory registration boards agreed that we should work towards the six-year standard to be comparable with international standards. That is really being put very much on the backburner with the introduction of this scheme and statements that have been made that we are not to increase the standards.

While the APS is not opposed to the ministerial council retaining some reserve power to act, 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 intrude into this, that is a legitimate reason, because it is protecting the public—but we see not for other reasons.

The independence of accreditation functions under the scheme must also be strengthened in the bill by limiting the ability of the Australian Health Workforce Advisory Council to get involved in accreditation matters, because we are concerned with the workforce pressure issue. It is important to recognise that, without these changes to the draft bill which more clearly secure the independence of the scheme's accreditation functions from government, the public's interest in the quality of training and practice as well as other hard-won arrangements for reciprocal recognition of qualifications with overseas countries may be put at risk.

Something new that I do not think was in our submission to do with accreditation is that there is nothing to do with conditional accreditation. When we go out and accredit the university programs, if they do not quite meet the requirements, they are not given full accreditation; they are given conditional accreditation, which gives them a period of time—usually up to 12 months—to going to back up to the standards. Usually the problem is the staff to student ratio, where they have had some staff leave and it has dropped below the required ratio. They actually use that as a lever to get the universities to put on more staff and meet the standards. It is not currently allowable in the bill, and we think this is quite dangerous. If you consider the students in these courses, you do not want to de-accredit the courses, or remove accreditation, straightaway because they do not meet one particular standard of a whole list. What you want to

do is force them to get back up and meet that standard. So we believe conditional accreditation should be brought in.

CHAIR—Professor Littlefield, are you aware of whether that applies to any other profession?

Prof. Littlefield—No, I am not aware of that. I do not know. It has been discussed at the accreditation professions council, and they were very much in support of that.

CHAIR—So it is an understood and well-known aspect.

Prof. Littlefield—Yes.

Senator HUMPHRIES—And each state presently has conditional accreditation arrangements.

Prof. Littlefield—Yes. We have a national scheme already—we do not have a state by state scheme—and it is in there. I want to briefly address term of reference b, the impact of the scheme on patient care and safety. There are two specific issues for psychologists. We are very concerned about two aspects of the proposed legislation as it applies to psychologists and we would like to make strong pleas for a review of the current content of legislation. The two issues involve protection of title and aspects of scopes of practice.

We argued in a previous submission that protection of psychologists 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.

Regarding the scope of practice in psychological testing, there is great risk to the public with open access and misuse of psychological tests. This is serious and concerning. There are significant arguments against this open utilisation of psychological tests, which are endorsed by not only the APS but the Council of Psychologists Registration Boards and APAC, the Australian Psychology Accreditation Council. To give some examples, non-qualified persons—in other words, people who have not been taught test administration, scoring and interpretation—do not necessarily administer the tests rigorously and, what is worse, they often misinterpret the results. This can have a lasting impact on a client’s life. The simple case is when a person’s ability can be assessed in terms of, say, a career and they are given back some information. Particularly when they are young and told: ‘No, you’re not suitable for that’ or ‘You don’t have the ability’, that can have an impact on their whole life. If the information is incorrect it causes lasting damage—and even more so with personality tests. In fact, this is why we had registration in the beginning. Scientologists used to do this sort of thing—that is, give people incorrect feedback on

their personalities—and the person then believes that for years to come. The worst case is misdiagnosis—there are some tests, people get a mental health diagnosis and they believe that they have that disorder and go off and get treatment for it, when the diagnosis may be incorrect. It really is very damaging. We think that, along with other protections of scopes of practice which are in bill B, the protection of some forms of psychological testing should be there.

They are my three points. If I get a chance I will come back, if you are interested, to the question asked of John Beever about the professions reference group, because I think there are other commonalities that he did not mention. I will leave it there.

CHAIR—Who is going next?

Prof. O’Gorman—Speaking on behalf of organisational psychologists, we support the goal of national registration of health practitioners and we are not seeking in any way to be excluded from the registration process. What we want is, firstly, to continue to deliver psychological services that are not health related and to be recognised as psychologists of equal parity in doing so. We want a clear and legally unambiguous complaints avenue for all clients of psychologists, not just those receiving health services. We want a system that will sustain specialist tertiary training and continuing professional development across the diverse fields of psychology, including organisational psychology, and we would like inclusion of workforce needs for all psychologists, including organisational psychologists, in future workforce planning. We see the move to generic health practitioner legislation and away from profession specific legislation as a threat to all those objectives, and it is for that reason that we raise our concerns with the committee.

In using a health practitioner template, the legislation to date, as we understand it, deems all psychological services to be health services, which is neither true nor helpful to the public who use such services. It is not true because the provision of health services, be they mental health services or health services more broadly, is but one aspect of professional psychological practice and one provided by only some psychologists. It is not helpful because it limits the protection the public currently has in using the services of a registered psychologist. It distorts the training of psychologists through inappropriate placement and competency provisions and, in the longer term, may restrict training places for psychologists in universities.

We have described in our submission what organisational psychologists do and provided examples of psychological service offered in other than health related areas; in our submission section 3.1 and appendix B are relevant. Our point is that health services constitute a subset of the broader psychological services, and legislation should recognise and accommodate this point. You may ask: is there any harm in continuing, for administrative convenience, the fiction that professional psychology can be taken to mean 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.

In the longer term, we see the too easy equation of psychological services with health services as limiting training opportunities in postgraduate programs to those directly concerned with clinical psychology. Our point is that psychologists can contribute to social welfare, wellbeing, performance and productivity by the application of their skills beyond the provision of health services. Legislation for the national scheme should not foreclose on those contributions. We are concerned that an important protection that registration should bring—namely, an efficient and effective complaints resolution process—may be denied under the new national registration system to the users of psychological services when those services are not health related.

To be concrete, 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. We are not lawyers and we have difficulty tracking the import of legislation in the various Australian jurisdictions, but we see at least considerable ambiguity arising under the new legislation for those who have a complaint about a psychological service, with respect to both where and how to pursue it.

The problem is not with the new legislation. Bill B defines a health service as that provided by a health practitioner, and it defines a health practitioner as one who practices one of 13 professions, which include psychology. Thus, according to bill B, as I understand it, whatever professional service a psychologist provides is a health service, at least for the purpose of bill B. It of course requires some nimbleness of mind on the part of a client of a psychologist in a work context to realise that he or she has received a health service and thus has access to the machinery provided by bill B. More importantly, however, the pursuit of complaints in the various states and territories is subject to courts, tribunals and health complaints bodies that have their own enabling legislation, and that legislation, not bill B, may well determine the complaints that can be pursued. Thus the agreed recipient of career guidance or of team counselling who is astute enough to see the service as a health service may still fail to have the complaint dealt with by, say, the Queensland health complaints tribunal, which defines a health service not as bill B does but as one provided to an individual for, or purportedly for, the benefit of human health. We understand that in Tasmania, for example, the relevant tribunal refused to consider a complaint about grief counselling because this was not considered a health matter.

We are not lawyers, but we think that plain words should mean what they say and that legislation enabling complaints should make the channels for those complaints obvious and accessible to the public. We have suggested in our submission what might be done to meet our concerns. Among those suggestions are, firstly, broad representation of the profession of psychology, not just the health relevant sections of it, on all boards and committees established under the scheme that relate to the profession; and, secondly, a transparent complaints procedure—one, for example, that would allow the psychology board of Australia to hear all complaints against psychologists.

We do not have all the answers to what are complex questions, but we are willing to pursue whatever discussions may be fruitful in this regard. What we do not accept, however, is that the goal of national registration provides a warrant to dismiss the difficulties we have raised. If we are to have generic rather than profession-specific legislation then the outcomes for the public

and the profession should be no worse than those that were available before the legislation was contemplated. Thank you.

CHAIR—Thank you. Mr Stokes?

Mr Stokes—Thank you. We have three other issues in the area that I would like to comment on. First of all, under term of reference (b), patient safety, clauses 217 to 233 in proposed bill B include references to the seizure of documents under warrant. Now, we understand the necessity for this process, but it seems to be less contained than our current practices in the courts scenario in the sense that, if you are required to provide documents under a subpoena to the court, you may request of the judge that irrelevant patient information or confidential information about a third party in that file be quarantined. There is no such provision in this warrant process. In the mental health domain particularly, there is often information on the patient file which is excessively sensitive and, certainly, as I said, includes third-party references which would be irrelevant to an investigation under these warrants. Our concern is that this needs to be more carefully addressed and there need to be some options for that sensitive, confidential information to be protected.

Going to term of reference (d), on complaints management and disciplinary processes, there are two issues that continue to concern us. We raised them in our first submission, but they were even more obvious in the draft of bill B. Clause 147 talks about criminal history checks, and there are three aspects there that worry us—first of all, that criminal history law does not apply, so both dismissed charges and spent convictions are accessible by the board in their criminal history check. It seems also that, under clause 167 and 172 and in a number of other spots, dismissed complaints against an individual never go away, so they sit there on the record in the board.

There seems to us to be something of an injustice or a trampling on human rights here that there are few protections built in that are normally built in to even criminal law proceedings and I think those issues need to be reviewed. Our suggestion would be that the word ‘charges’ be removed from the phrase, that dismissed complaints would be expunged and that the criminal history law applies.

Secondly, in that area there is mandatory reporting. We have expressed concern from the beginning about this whole issue and clauses 156 and 157 particularly bear on this. This is mainly because the whole notion of collegiate support, mentoring and even supervision are undermined by the provisions that have been made about mandatory reporting. We recognise that to some extent there is a fine balance here. What goes over the balance as far as we are concerned is first of all that a therapeutic relationship between one practitioner and another where practitioner one may be engaged in psychotherapy with practitioner two is immediately threatened by the mandatory reporting requirements. Unless the word ‘substantial’ specifically is added into this context so that you do not get knee-jerk responses and frivolous or overactive reporting the opportunity for therapeutic relationships to go forward is undermined.

Even worse are the mandatory reporting requirements for employers. This might seem somewhat less noxious in the health setting where there is an understanding perhaps between the director or the manager of that service, but remember that 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, once again, you would never have mentoring and supervision in a context where that threat hung over the employer. There is 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. I think they are our major concerns with the remaining elements of bill B.

CHAIR—Thank you. Professor Littlefield, do you want to go back and touch on the point that Senator Boyce was raising about the professional group, now and then we will have everything on the table and then we will go to questions.

Prof. Littlefield—In fairly recent times the profession's reference group came up with three things that it agreed on. One was the concern about independence of accreditation and we have covered that. The second was the relative powers of the national agency and the national boards and that was to do with who set the budgets and who set the registration fees which obviously have to pay for whatever the budget sets. The idea was that the national boards should set their own budget, decide what they needed to do, purchase services from the national agencies, such as IT and financial support et cetera, and then obviously the registration fees would be set to meet those costs.

Senator BOYCE—Did you think the changes that were brought into bill B helped—

Prof. Littlefield—I thought they were better.

Senator BOYCE—Better, but could still do with some more work?

Prof. Littlefield—Yes.

Senator BOYCE—Do you have any suggestions?

Prof. Littlefield—Not right here. I could send you some though.

Senator BOYCE—That would be excellent, Professor Littlefield. Sorry to interrupt.

Prof. Littlefield—The last one, which is a perennial one, is who should pay for the entire system. At the moment it is the professions totally paying where the system is largely for the purpose of protection of the public. All of the professions obviously would like to see some sort of split in costs with some paid by the professions, no doubt, but some by the public purse as well.

CHAIR—Who pays for the boards now?

Prof. Littlefield—As a matter of fact it is interesting. If you talk about registration, I am sure by and large the registration fees do pay, but accreditation is quite a different process. Whereas in our case, for instance, the APS pays half, along with the registration boards, we put in a lot of money to the scheme. Not only that, but all the site visits to the universities are done out of the goodwill of our academic membership. Sometimes eight or nine members go on a site visit for five or so days and they do not get paid for it. The question is whether, when it is not the APS,

when it becomes a national scheme, people will be willing to do that. It costs the APS hundreds of thousands of dollars each year.

Mr Stokes—In the state registration scenario it depends what the arrangement is. In those states which have attempted self-funding by the registrants, it is up around the \$360 to \$500 level. In the Northern Territory, by contrast, where the government seems to fund most of it, I think it is \$25. So there is a fair—

CHAIR—That in itself has been a discussion point.

Mr Stokes—I am sure, and a very vexed one.

CHAIR—In the discussion that has been had it all the consultation processes about payment, has this been on the agenda, Professor Littlefield?

Prof. Littlefield—It has been on the agenda almost all the time. It got no response at all.

CHAIR—No response as yet?

Prof. Littlefield—No.

Senator HUMPHRIES—Can I first go to the point about the accreditation body. Your understanding is that the government gets to appoint the body that will accredit people in those areas, not the individual members of the accrediting body?

Prof. Littlefield—No, the body.

Senator HUMPHRIES—There was some confusion with the earlier witnesses about that, but I think your understanding is correct. I suppose that power needs to be preserved in the legislation, doesn't it, if there is more than one body that might conceivably be qualified to accredit? Someone needs to decide who actually has responsibility for accreditation. That is how I would have read that power.

Prof. Littlefield—Yes.

Senator HUMPHRIES—But you seem to be raising the problem of the government possibly playing one potential professional body off against another by switching accreditation responsibility in a political context. Is that really a significant concern, and how do we—

Prof. Littlefield—One would hope not, but if there is no suitable accreditation body the ministerial council can actually appoint some form of body or a committee. What does not appear to be in the legislation is on what criteria they would appoint that. One would hope it would be people of expertise and experience in accreditation who really do not have a political workforce agenda. So it needs clarification really. At the moment it is my understanding that all the accreditation bodies have been appointed for the coming three years and that, apart from one or two professions, it was very clear-cut and there was not too much of what you are describing. But in the event in three years time who knows what will happen. It is just a safeguard that we are asking for—that if it were the ministerial council that did that then they would have clear and

transparent logical criteria for that appointment and it would not be on a political or workforce type basis. That is our concern. The other option is to devolve that power to the national board to do the appointment.

Senator HUMPHRIES—That is fair enough. I have a question about areas of need. A number of professions have made the point to us that you cannot compromise standards in order to deal with short-term or regional issues which require some sort of compromise in standards to get services covered. I think that is a reasonable response. But is there room for us to construct our registration mechanism in some way so as to deal with those issues? Is there any compromise possible in these areas so that you actually deal with the very real problems of some parts of Australia at the moment not having access to anything like adequate numbers of professionals for those places?

Prof. Littlefield—There is certainly concern not only in geographical areas, such as rural and remote, but also in specific context. For instance, there are not nearly enough psychologists in aged care in drug and alcohol services. They are desperately needed. I think there are other ways of building that up rather than by diminishing standards. Why should people who live in rural areas or people who are aged get a lesser quality of person, a lesser trained person, than anyone else to treat them? That is very inequitable, in my view.

Senator HUMPHRIES—If it is a choice between not having anybody or having a lesser trained person, is that not a reasonable situation in which to postulate getting in those lesser trained people?

Prof. Littlefield—We have been working very hard trying to fill the gaps. In drug and alcohol services we now have placements of our final year students, which will build them up and keep them in that workforce. That is a slower process, but it is actually working. We have about 80 services now in Australia with people who are being trained to be there. In rural areas it is interesting. You know, there are the same numbers of psychologists as GPs in rural areas. People do not realise that, but it is the same number. GPs have special incentives to go there; they get relocation costs—there is a list of things they get. If it were the same for allied health professionals, not just for psychologists, I am sure people would move there as well. If all that fails, which would not at all be my preference, that could happen with people who are very close to qualification—but under really direct supervision, and that would be the criterion. You could put people out there who do not meet the registration requirements—but only under the supervision of experienced practitioners who do.

Senator HUMPHRIES—That very rare exception is not really covered by what is in the bill at the moment? Do you think that should be clarified in some way?

Prof. Littlefield—Yes. It is a poor option. I am thinking of aged care. My mother has been in aged care, so I have had long experience with it. I suspect that someone will say, ‘Oh, it’s good enough.’ It is seen as ‘good enough’, and then standards drop because they say, ‘We’ve had that sort of person and it has worked, to a degree, so why should we even bother looking for the more qualified person?’ I am worried about a trajectory that diminishes standards.

Senator HUMPHRIES—Yes, I think that is a very valid concern. You talked about psychological services not delivered by psychologists. Can you give an example of that.

Prof. Littlefield—I think the public believe that if they are going to get psychological services they will be delivered by psychologists. There is an implication there. At the moment under initiatives in Medicare such as the Better Access to Mental Health Care Initiative and the Better Outcomes in Mental Health Care Initiative other professions are doing that, and they are much less qualified to do it than psychologists.

Senator HUMPHRIES—Other than doctors, who else does that?

Prof. Littlefield—Social workers and OTs. But doctors in particular have 20 hours of training to deliver focused psychological strategies, whereas psychologists have years of training to do it. The public would think they are getting the same service because that is its name. So we are arguing that, if you are going to use a derivative of the term psychologist, it actually does mean a psychologist is delivering it; otherwise, it is misrepresentation.

Senator BOYCE—Would making that change restrict the ability of anyone other than a psychologist to deliver counselling services in that area?

Prof. Littlefield—We are only arguing for the derivative of psychologist. Counselling is a whole other term.

Senator BOYCE—Sorry, I was using ‘counselling’; I did not use ‘psychological services’, but let us use that term. Would that amendment, if it were to be accepted, restrict the ability of social workers and GPs, for example, to offer psychological services?

Prof. Littlefield—They could be called something else like ‘mental health services’. I think ‘counselling’ is quite a dangerous word because ‘counselling’ can mean anything from six weeks at one night a week—

Senator BOYCE—Absolutely—at a meditation centre.

Prof. Littlefield—That is right, so ‘counselling’ is quite a dangerous term. It could be something more generic like ‘mental health services’. We are really saying that ‘psychological services’ implies to the public that it is a psychologist.

Senator BOYCE—So you are concerned about the descriptor not about restricting the services?

Prof. Littlefield—Yes, and describing what whoever does accurately to the person.

Senator HUMPHRIES—We heard earlier today that doctors can prescribe spectacles. I doubt that any doctor I know has ever done that or would be able to do that, but that is within their powers. I suppose they have lots of residual privileges which perhaps they should not be entitled to exercise. I was a bit disturbed to see you repeat the comment that you have made in previous inquiries this committee has done about the period of qualification that psychologists need to undertake in order to do their professional practice. You make the comment that Australia lags behind world standards in setting and promulgating qualifications for professional practice. Do you think that the NRAS might be an opportunity to address that if it is focused on that?

Prof. Littlefield—I do, because once we are under a national scheme we are not at the behest of each individual state and territory government. We have tried to address this over the last 10 years individually with each state and territory, but they operate as they see fit and we have not been able to get uniform agreement across them all. Hopefully, with a national scheme somehow or other they can be brought together to look at that.

At the moment, exactly half of our training psychologists do go through the six-year scheme—we have managed to get it up to that number—and half currently do the four-plus-two scheme. The worry with that is that the plus two, which is like an apprenticeship under supervised practice, is very variable—you can get a good place with a fantastic supervisor or a place that is not so good with a not so good supervisor. We are actively looking at tightening that even by having five years at university plus one year of supervised training, so the variability is not so great and they have more rigorous input in the fifth years and have examinations at the end of those supervised pathways to ensure competency standards are met.

Senator HUMPHRIES—Is there any risk that Australians do not have that transportability of skills between here and other countries?

Prof. Littlefield—We absolutely do not. We are trying to get it. For instance, our society works very closely with the British Psychological Society and we have not been able to do it. We are in consultation over it but Australians who go over there have to do extra training before they are recognised, and it is the same with America. It is just the way the world looks at us. We really do not want to be below international standards.

Senator HUMPHRIES—No, and in most respects in other professions we are over and above international standard, so it is a pity we are not in that ballpark here.

Prof. Littlefield—I know.

Senator CAROL BROWN—We have not touched on the appointments that will be made to the national boards for each profession. Are you happy with the proposed make up of those boards?

Prof. Littlefield—No. What we gather from the formula that has come out is that the boards are going to be nine people, six of them will be of the profession and five of the six will represent the major states and the sixth person will be someone from either the ACT, Tasmania or the Northern Territory. Is my understanding correct?

Senator CAROL BROWN—That is right.

Prof. Littlefield—The Australian Psychological Society have made a set of nominations for the board. I do not know whether you realise we now have 17,500 members. We now have a huge proportion of psychologists who are members of the APS. We had an enormous pool of people who had expert experience in registration and accreditation. So we called for expressions of interest from people to stand for the board. We received a lot of expressions of interest and we were able to make a selection of about 15 people who had absolute expertise in registration and/or accreditation. Then, after doing that, we discovered this formula. It 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 which I will not name, 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.

Senator CAROL BROWN—I will just declare I am a Tasmanian.

Prof. Littlefield—We put someone up from Tasmania!

Senator Boyce interjecting—

Prof. Littlefield—And also from Queensland!

Senator CAROL BROWN—Something that has been brought to my attention by some—

Prof. Littlefield—I think it is a great pity; you want the best people in Australia.

Senator CAROL BROWN—But you need to have a limit on how many you have on the board. How would you suggest that it be—

Prof. Littlefield—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.

Senator CAROL BROWN—But your suggestion would be that you have the best possible people who put their names forward, but you are not so much interested in geographic positions being created?

Prof. Littlefield—It so happened that we would have had them from all bar one state.

Senator CAROL BROWN—But that is not your primary concern?

Prof. Littlefield—No. In setting up such a new scheme, which is critically important to our professions, our primary concern is that we get the best people on that board and that, in our mind, those are people experienced in governance, registration, accreditation and with diversity and, as John said, includes at least one non-health psychologist amongst them. There are other concerns that we have beyond state representation.

Senator CAROL BROWN—Do you not believe that in having, at least, a representative from each of the states, that they bring local knowledge of what is happening in their jurisdiction and that would benefit the boards?

Prof. Littlefield—Yes, I do. I think the solution, having once heard the formula, is to just go to a slightly expanded board to get a couple of extra people who have real expertise, so have the state representation but have a couple more who have real expertise, who will miss out. There

are two fantastic people we put up from New South Wales. One will miss out with this formula. They would almost be the best two in Australia whom you could have. I think it is a great pity.

Mr Stokes—The word ‘representation’ is flawed, anyway, because 70 per cent of psychologists are in New South Wales and Victoria, yet they get only one each of the six. So, in a sense, their attempt to have state representation does not necessarily reflect the notion of representation, either.

CHAIR—A few of the organisations now have a national scheme, so this process is reflecting all the participants in this new arrangement. To the best of my knowledge, psychologists are about the only ones who have a current national scheme. The rest are all based on state boards. In terms of bringing together a new structure it was a way of actually saying, ‘We are at least acknowledging that all the states are feeding in.’ The fact that you have progressed to a national structure when you did puts you well beyond—I cannot think of another one in the 14 who currently have a national system, so that is the tension.

Mr Stokes—Understood.

Prof. Littlefield—We understand that—

CHAIR—It is just difficult when you are already operating in a national framework.

Senator BOYCE—Professor O’Gorman, could you tease out a little bit more for us what you think we should be doing to address the issue you raised about psychologists working in non-health areas? You have set out some suggestions in one of your submissions about the psychology board of Australia having the unambiguous power to investigate complaints for all types of psychological services. How does this come into the bill itself? Is your concern that we need to spell out that psychologists who do not deliver health services should be under this auspice or aegis as well?

Prof. O’Gorman—The issue has to do in part with the clients of psychologists in non-health areas. The legislation is within the health domain. It is a health practitioner framework that is informing the whole thing.

Senator BOYCE—And you have to squeeze yourself in somewhere.

Prof. O’Gorman—That is right. For the client it is not at all clear that they have any access when they are not receiving a health related service—for example, vocational guidance. If I have a complaint about the service that I have received it seems a little strange to have to take it through a health tribunal, if in fact that health tribunal will hear such a complaint. Bill B defines ‘health practitioner’, ‘health service’ and so on—

Senator BOYCE—But in a way as to exclude you by the definition.

Prof. O’Gorman—We would trust that we were included. In the early days we got an opinion which suggested that we might not; however, I think bill B has tightened it up so that the definition would cover what we are doing, but it is still covering it within a health context. The

client would not necessarily see that what they are receiving from the psychologist is a health service; therefore they might not see that they have any redress.

Senator BOYCE—You have four suggestions around common legal requirements, international mobility, secondment of people around workforce planning areas and the power of the psychology board to investigate complaints of all kinds being very clearly spelt out. That completely addresses the issue in your view and is going to give consumers that knowledge.

Prof. O’Gorman—We would think so.

Prof. Littlefield—There are two states with current legislation under a health act that have required all psychologists, including organisational, to do specific things in their training that train them to be health practitioners and that do not necessarily train them to be organisational psychologists. Also, for mandatory professional development, at least one of these states has said you have to do it in a health or clinical area.

Senator BOYCE—Which states are you talking about?

Prof. Littlefield—New South Wales is the main one and Victoria somewhat. They are asking them to do things which are really not in their scope of practice, and they will not register them unless they do them.

Senator BOYCE—I was under the impression that psychologists would all do three to four years of core study.

Prof. Littlefield—The first four years are core and then on top of that—

Senator BOYCE—And then the two years would be when you start to specialise in a particular field.

Prof. Littlefield—That is correct.

Senator BOYCE—So you are being forced to do two years as a psychologist offering health services before you can go on and become an organisational psychologist, as an example.

Prof. Littlefield—It is in the pathway of the four plus two, the two years supervised pathway. They are being forced to do clinical type placements rather than organisational placements, and under professional development it is the same.

Mr Stokes—It is not total but it is a proportion, so they are required to meet certain standards or a portion of their supervised period in a mental health or clinical setting.

Senator BOYCE—And you would argue that this is a waste of time and resources.

Prof. O’Gorman—That is right. For people who are not planning to practice in that area and who would not be able to practice in that area because that is not their expertise, this is a complete waste of their time. Their effort would be better spent on working in a context in which they wish to practice.

Senator BOYCE—The fact that the medical model is dominating psychology is your primary issue. You believe it can be fixed with some changes that acknowledge that, whilst you are in a health system about delivering health services, not all psychology is delivered as the health service. That will satisfy the problem in your case.

Prof. Littlefield—Absolutely.

Senator BOYCE—Thank you.

CHAIR—I am sure there are many questions because there are so many issues that relate particularly to your area and that will continue with the consultation process. I am interested in whether you have any comments about the consultation process that has occurred. It seems to have been going on forever but is there anything that you want to put on the record about how the process is operating?

Mr Stokes—Are you talking about the immediate forum or the overall process?

CHAIR—Both. In terms of the way this has been operating it has been said that there has been extensive consultation and the process continues. Your organisations have been deeply involved in many government interactions, I am interested in whether you have any comment for the record about how this process is going.

Mr Stokes—I guess the only comment we would make is that there has been a very thorough and comprehensive opportunity for comment. It would be fair to say that it seems as though a number of our comments fell on deaf ears. We understand that it is a complex process trying to meet the needs of 10 professions but some of the issues, even those that we raised earlier, do not seem to have been reflected in modifications or changes. To some extent we found it a shade frustrating. Even though it was productive to have the opportunity, it has not always impacted in the way that we might have hoped.

CHAIR—Has there been a direct response from the process people? I know it is being run through the group that Dr Morauta heads linked to health. When you raise issues and they are not picked up, do you get information back as to why?

Mr Stokes—No.

Prof. Littlefield—Really we have had a lot of opportunity. Louise Morauta has made herself very available. The professions reference group meets independently, we try to get a common voice and we then meet with Louise Morauta. All of the issues that I think we have raised today, we have raised for six to 12 months with no change and no response which is why we are raising them here today.

CHAIR—Certainly, and that is a process that we are part of in terms of the role of this committee, but it seems to me that very rarely do you get everything that you want in any situation.

Prof. Littlefield—We understand that.

CHAIR—It would be useful to have an explanation as to why something has not happened.

Mr Stokes—Absolutely.

CHAIR—We will take that up. Thank you very much.

[11.44 am]

BOYD-BOLAND, Mr Robert Noel, Chief Executive Officer, Australian Dental Association Inc.

HEWSON, Dr Neil, Federal President, Australian Dental Association Inc.

CHAIR—Welcome, Gentlemen. You both have information on parliamentary privilege and the protection of witnesses. That is standard information and if you need any more the secretariat can provide it for you. We have your submission. My understanding is that this submission was written before the last communique, as we know because the process has taken so long. Obviously, there have been some changes so when we get to questions you may want to see whether they are highlighted along the way.

Mr Boyd-Boland—We are preparing a response to the bill and, obviously, we would be happy to provide that response to you. You would be accessing it anyway but if needed we would be happy to provide that response.

CHAIR—I invite either or both of you to make an opening statement before we then go to questions.

Dr Hewson—Right from the start the ADA has been a very strong supporter of regulation of dentistry and it has been supportive of the concept of a national system. While national consistency has not been an issue for us, it has been an issue for the other three dental practitioners and we have always believed, for a whole series of reasons, that scopes of practice and things like that should be nationally consistent. We were listening at the back of the room and doing a lot of nodding and it is interesting to note the common concerns that people have even though each profession does have its own special areas of concern. I suppose a couple of things make dentistry different. One is that it is a surgical profession whereby you are doing irreversible and invasive procedures. Most of the other health professions are more of a consultative nature. Also, in the regulation of this, dentistry is the only group that has four different professions in it—and you might say that of the divisions of nursing—so that does make us a bit different.

CHAIR—Dr Hewson, this is just for the record. I know all this is in your submission but do you want to read into the record the four different groups?

Dr Hewson—Yes, for dental practitioners there are dentists and that category includes dental specialists or specialist dentists, dental hygienists, dental therapists and dental prosthetists.

CHAIR—Thank you, and that is just for the record.

Senator HUMPHRIES—Is ‘dental surgeons’ still included in there as well?

Dr Hewson—That is another name for dentists. There is a whole lot of different titles that might need to be protected, as opposed to having the four different professions. Dental

prosthodontists deal with dentures, full and partial, and mouthguards. Dental hygienists are about cleaning, oral hygiene instruction, scaling and root cleaning. Dental therapists have by and large been doing simple restorative procedures on children up to 18 until recently in the public sector.

CHAIR—Thank you, Dr Hewson. I think it was useful to get that right on the record at the start. Please continue.

Dr Hewson—We have been a little bit disappointed that the system seems to have been growing and becoming more complex and more bureaucratic. Some of the efficiencies that we hoped for do not seem to have been happening. Another thing we are a bit worried about is that we are not going to end up with a national system so we are going to end up with a national system and a state and territory system and there will be different systems for complaints. So despite our efforts to have a system to create consistencies it looks like we will not be able to have that. Some examples include that the Public Interest Assessor might act in some jurisdictions but might not act in others and that some will have local—now called state—boards, which once again we think is a bit confusing, and others will not. We, like the fellow health professionals who gave evidence before us, have always been advocating to try to get the system simpler and to maybe not have things like the advisory council and a few other things like that—all to try to get the system simpler. But we do understand there are problems when you have eight different groups trying to put a body together. We have concerns as to the objects of the proposed act. There is a bit of a trend in the proposed act whereby things are set up and then in a section in the last part of it there is: ‘Oh, well, if something happens we can disregard all of the above.’ That seems to be a little bit of a trend in this legislation and we have concerns about that. In the objects we would like to see that safety and quality issues have some status above the ones about perceived need in areas and some other things that may lead to a lowering of standards.

We also believe that the ministerial council potentially has too much influence over national standards and over the accreditation processes. We have always been a very strong advocate of the accreditation processes and the board processes being separate. We understand that not all health professions are as well resourced as us and are in a position to immediately go on that. We believe that should be the ultimate model and that those roles being separate does improve safety.

We also have problems with the make up of the board, particularly given the special nature of dentistry. We understand that people love to have a one-size-fits-all and have us all fit into a nice little model. Given that we do have more than one type of practitioner and that we have only one practitioner who has the training and expertise to cover all of dentistry, we believe there should be more dentists on the board and that the dentist should be the chairman. That fits in with the model everywhere else where they are recognising that you need the expertise in the chairperson. We have made various submissions over various times about the make up of that. We fully support all of the other professions being represented on the board.

One of our major concerns in sections 124 and 42 is the role of health funds. We do not believe that you can have an equivalent of someone being disciplined under the Medicare processes as you can apply that to derecognition by a health fund. We do not believe that should be in the act. Health funds do not have open and transparent processes. In fact, we have actually got on record where one of the health funds has told one of our branches that they do not believe

that if they derecognised a practitioner they should adhere to natural justice. That is of great concern.

In line with the area on restricted dental acts, I think there are four different criteria where you said that only people who are dental practitioners can practise dentistry and then you end up having two exceptions, one for dental technicians who may in the process of making dental appliances practise dentistry—we are not sure whether that would be the case or not—and then the catch-all in regulation that anyone else can do it. Once again we think that as dentistry has been recognised as needing to have restricted practice it should be restricted to the people in the act. If something in the future happens, that should be done in the act not once again by having what we call an ‘escape’ clause at the end.

We also have some problems with the mandatory reporting. We believe that there are problems with family members treating family members and that mandatory reporting there if one of them happened to be another health practitioner. 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. Of course, if they are not happy then they can go through the other processes. 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.

Senator BOYCE—What states does that complaint system work in?

Dr Hewson—I think it is just about all, except maybe Tasmania and the Northern Territory. They vary slightly, differently, from branch to branch, but in most branches they are called community relations officers. So what they try to do, if a patient makes a complaint, is investigate it, ask the practitioner to reply and then see if there is some resolution. Most of the time they solve most of the problems with a first phone call. But then there is a more formal process. So in Victoria, my state, that process works very closely with the Health Services Commissioner, the complaints commissioner. Sometimes we send each other different patients.

Also, we have some concerns, because of the complexity, about the costs. They vary in jurisdictions too. For dentistry in New South Wales the registration fees are much less because of the HCCC. The ADC is actually funded by the boards and by the professional organisations who are members of it. It also receives fees for examining overseas trained dentists. So it is by and large at the moment supported by the profession.

CHAIR—From your perspective, and you, Mr Boyd-Boland, as you are doing the response to the second part, have any of those issues been picked up in the revised bill, in bill B?

Mr Boyd-Boland—Those issues will be raised in the further submission.

CHAIR—None of them have been addressed to your satisfaction in the bill?

Mr Boyd-Boland—No. On those issues, no.

CHAIR—I did not think so, but I just wanted to make sure that you were not going over old ground.

Mr Boyd-Boland—You could say with the independence of the accreditation authority there has been progress, but there still is that catch-all at the end.

Senator HUMPHRIES—Talking about consultation, I noticed that in your submission you mentioned you made 10 submissions to the Health Workforce Principal Committee. Why did you have to make so many submissions?

Mr Boyd-Boland—We were asked 10 times to make submissions. They were all submissions in relation to various aspects of the process.

Dr Hewson—And at the same time there were so many other things going on, too. We were in total submission overload.

Senator HUMPHRIES—Has a large proportion of what you put in your submissions been reflected in the final version of bill B, do you think?

Mr Boyd-Boland—As Dr Hewson said, a number of the matters have been addressed, but they have not gone the distance that we would like them to have gone, and we think further improvement is available.

Dr Hewson—I was at a meeting of department officials late last week, and there were comments made by them that they believed that bill B still required a lot of work, so that was reassuring.

CHAIR—They did not say it is perfect now?

Dr Hewson—No. But you do wonder. You feel like you are nagging a bit sometimes. That was nice. It was reassuring to hear that.

Senator HUMPHRIES—We are here to hear the nagging, so feel free to nag away. You refer in the submission to the question of setting professional standards. You say that the creation of professional dental standards must rest with the national dental board. They have appropriately trained practitioners with the appropriate level of skill and knowledge. Do you think what is in bill B now gets that balance right? It is mostly practitioners and a few consumer reps on the national board reporting to the ministerial council, and it is only rejectable by the ministerial council if it meets certain very restricted criteria. Is that a reflection on what you have put in here as the ideal?

Mr Boyd-Boland—We were given an outline as to what the make-up would be of the Dental Board of Australia. We do not think there is adequate dentist representation on that board. As Dr Hewson indicated, it is the dentist that holds the expertise to practise in all areas of dentistry, whereas some of the other professions that would be under the auspices of that board or under the control of that board perform limited aspects of the practice of dentistry. We would therefore think, to the extent that they would be commenting on those particular areas of practice, that they would be competent to comment, but in relation to an overall analysis of appropriateness of standards and the like there ought be additional dentist representation.

Senator HUMPHRIES—So you are happy that the board is dominated by people with professional interest in dentistry, but you think the break-up between the different subsets is not appropriate.

Dr Hewson—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. We also believe, from experience with other combined boards like this, both overseas and in Australia, that consumer representatives are important and that transparency is really, really helpful. But we believe that, as is the case with other, current state and territory boards, you need to have that dental expertise and you need more dentists.

Mr Boyd-Boland—It is a peculiar body, the Dental Board of Australia. It is going to be looking after four professions. We do not think that adequate recognition of that difference has been provided in bill B. The bill still does provide 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.

Senator HUMPHRIES—The break-up of the board—who gets appointed from which occupational group within dentistry—is not a matter that is actually in the bill, is it?

Dr Hewson—No.

Mr Boyd-Boland—No.

Senator HUMPHRIES—So this is a matter of discretion, if you like, on the part of the ministerial council as to how that is made up over time.

Dr Hewson—But it needs to be outside the guidelines a bit. The maximum two-thirds probably needs to be stretched a little.

Mr Boyd-Boland—When nominations were called for positions on the board, there was an indication as to the precise make-up of the Dental Board of Australia. That was going to be three dentists, one of each of the other professional groups in dentistry and then the community representative.

Dr Hewson—We share the concerns of the psychologists about the later requirement that there be state representation. Once again, these boards are meant to be expert and we need the very best people. In dentistry you could have, say, a dental prostheses person representing Victoria. You could have someone who only practices in that small area of dentistry supposedly representing all the dentistry from that state. One of the things that struck me in the conversation that you were having previously was that perhaps that is a role, if you are worried about local conditions and things, for the state committees or state boards to report to the national board. I do not know. It is just a thought.

Senator HUMPHRIES—Did you still have a concern about the amount of power the ministerial council has vis-a-vis the decisions of the board?

Mr Boyd-Boland—There is a power in section 10 that enables the ministerial council to provide directions to the board. It was asked in one of the consultation meetings what that meant, and it was indicated to me that, if the ministerial council was to provide a direction, it was to be followed.

Senator HUMPHRIES—But there are restrictions on when it can be exercised in that section, aren't there?

Mr Boyd-Boland—Yes, there are in relation to areas of need and the like. We would say that areas of need are something that needs to be addressed but that safety and quality are paramount. Provision of a directive that might compromise safety and quality yet meet an area of need demand would be inappropriate.

Senator HUMPHRIES—I suppose people would argue that meeting areas of need requirements necessarily involves some compromise with other standards in some way. That is the argument, isn't it: do you allow people with lesser qualifications to practice or something like that? With the previous witnesses, there was a concession that in some limited circumstances you might need to do that and that is why such a power might need to be preserved. Would you concede that that is appropriate?

Dr Hewson—One of the other problems with dentistry is that you have to set up a mini operating theatre. We have strongly supported and advocated that the incentives that are provided to doctors to practise in rural and remote areas should also apply to dentists, but there are going to be areas where it is just physically unviable to have a dental facility. Perhaps one of the solutions is to have some system where people can be brought to practitioners. Dental practices are extremely capital and labour intensive and are very expensive to set up. Whereas someone like a psychologist can come into an area and use a room in a doctor's surgery or something like that, you cannot do that in dentistry.

Senator HUMPHRIES—I have one last question. You make the point that this is likely to lead to more administrative costs and complications—red tape. In your opening comments, Dr Hewson, you made reference to there being even more people to deal with than in the past. One would have hoped that the outcome of this exercise, where once you had 80 different boards running aspects of registration and now you have only 10, would result in less bureaucracy and theoretically lower costs. Is there anything that you see in these arrangements which is inherently unlikely to meet that goal?

Dr Hewson—I think we have had concerns about the agency managing committee; we thought that that was unnecessary. We support the concept, as is the case in Queensland, of a central administration for a series of boards. I think that also happens in the Northern Territory. They are all good ideas. But every time I see the scheme, such as when I look at it on this piece of paper, there is another box and another two or three arrows, and I guess there are concerns.

Mr Boyd-Boland—The agency management committee was a level which we thought could perhaps be eliminated. Its function is to decide policy for the national agency, and we see that role being duplicated by the ministerial council and the Australian Health Workforce Advisory Committee. The agency management committee to us seems superfluous in the design.

Senator CAROL BROWN—I might just touch again on the appointments to the boards. I understand the point that you make about the state boards or state committees which may be set up, but the primary role of those committees or boards, as I understand it, is in registration and complaints. Is that correct?

Mr Boyd-Boland—Yes.

Senator CAROL BROWN—Also, as I understand it the appointment to the dental board would give dentists and the other professions six positions. Is that correct?

Dr Hewson—Yes. That was—

Senator CAROL BROWN—And one of the practitioners would be chair of that board.

Dr Hewson—Yes.

Senator CAROL BROWN—So it would be three dentists and one from each of the other professions.

Dr Hewson—Yes.

Senator CAROL BROWN—I wanted to confirm that. The other issue I have is about whether you think that they should be based on geographic criteria.

Dr Hewson—We did not see that as being so important. But if that is going to be a criterion, if you are using the model that is everywhere else where you only have the single practitioner, then the geographic considerations should be concerned with dentists, and the other practitioners should be there to represent those practitioners. That is why we are saying there should be at least five; that at least gives you the five major states.

Senator CAROL BROWN—What I am actually interested in is your position. Basically, you are not that concerned that it is not geographically based. You are more concerned that the expertise is there.

Dr Hewson—Yes. But we have had some concerns that perhaps you might not get such a good board if you have to have the geographic basis to it, that the expertise on different boards may vary. But, once again, that is very hard to judge. We also took the liberty of recommending a board, in a sense. We put up the names of various people who we thought filled a lot of the criteria, because there are criteria about education and things like that as well. We also nominated other practitioners, with their consent. In fact, they were very pleased that we had approached them.

Mr Boyd-Boland—That is, representatives from the other dental professions.

Senator CAROL BROWN—How many did that total? Was that nine? How many did your board consist of?

Dr Hewson—I am not sure if we got four or five dentists in the end. It was towards our model.

Senator CAROL BROWN—I take it that your profession have them nominated, because it is closed.

Dr Hewson—Lots of other people nominated, too.

Senator FURNER—The bill proposes a mechanism for complaints management and disciplinary process. Has that concerned you with respect to what they are proposing to do in that field at all?

Dr Hewson—We have had some concerns because the Public Interest Assessor is something that we had not heard about until just recently. There had never been any discussion as to whether that was a possibility, so that was a bit of a surprise. We have been given explanations that in small jurisdictions like the Northern Territory, where there is something like only 50 dentists or even less, it is very difficult for people who are on boards not to have personal relationships with other practitioners. So we understand the necessity for that, even though my experience and the experience of other larger jurisdictions is that once you get the dentist not deciding the penalty dentists get lesser penalties—we are often harder on our peers than on other people. We have had some concern that we did not want the Public Interest Assessor to become a complaints system where it was about commercial disputes and things. We believe that bill B does not make clear the processes they should have, the criteria for what they are doing, that what the boards are doing should be the same so that they just concentrate on professional standards, and that if people have disputes they should use the state dispute systems.

Senator FURNER—What is the current practice in terms of disciplinary matters?

Dr Hewson—It varies from jurisdiction to jurisdiction, but usually a patient or someone else can make a complaint to a board. Many of the boards have employees who are investigators. It depends on the boards. On the medical practice board of Victoria there are lawyers. Some of the medicos in the dental practice board of Victoria are dentists. They then go through a formal investigation process and make recommendations to the board. The board then decides whether it will become an informal hearing, whether there is no case to answer or whether it is a peer practitioner so that you need to go through a different process, or you can go to a formal hearing. That has been the general process that has happened up until now.

Mr Boyd-Boland—Could I also raise that we were concerned in relation to the board's ability to deal with the number of complaints at the one time. I can see reasons of expediency in relation to that, but we think it unfair that a board may be unable to consider a complaint that might deal with performance and a complaint that might deal with some other aspect of practice all at the one time when none of those actual complaints have been proven at any time. I just thought the ability to look at a multiplicity of complaints that may be unrelated was inappropriate.

I thought the ability that the board was given to seek information from other patients of the practitioner was also inappropriate. We think that would prejudice the professional relationship that exists with the patient. If a patient is asked questions in relation to a particular practitioner's performance, that would instantly raised some suspicion or doubt in the mind of the patient as to

the ability or bona fides of the professional. We are also concerned that in certain circumstances the board could take immediate action, which would amount even to suspension of an ability to practise, based only on a reasonable belief. A far higher level of certainty in relation to particular activity ought to be established before immediate action by suspension of a practitioner's right to practise could occur.

Dr Hewson—Just to clarify one of the things that Robert was saying, we do not think it is unreasonable for a board to deal with multiple complaints; we think it is unreasonable for them to deal with them as one issue—and that is what the act allows. If the multiple complaints related to exactly the same concern of professional standards, then that would be reasonable, but if they were in completely different areas we believe that natural justice is that they should be judged separately.

Senator BOYCE—So your concern there would be that perhaps an investigating body might go on a witch-hunt. After having a particular type of complaint brought to them, they might go looking for other things to investigate. Is that what you are saying?

Dr Hewson—There has been some view that that does happen in some jurisdictions already. You will not know the terminology, but you try and fill up the charge sheet a bit. If, say, there was a practitioner who did a lot of crown bridge work and the board had five cases of people complaining that their crown bridges had fallen out, then to us it would be reasonable that they be dealt with. But if someone else said, 'He was rude to me' or 'He didn't wear his mask properly' or made some other complaint that was completely separate, we believe that those complaints should be dealt with separately because they would have different ramifications.

Our belief about regulation is that the first port of call is for the boards to make that practitioner safe; discipline should be a last resort. If you are protecting public safety, going back to that crown bridge thing, you might just say to the practitioner, 'If you agree not to do any crown bridge work until you do further courses we will put that condition on your practice.' That protects the public. The practitioner can then choose to improve their knowledge, skills and expertise—or not—in that area and stay with the level of practice. We believe that that is the way these complaints systems should be directed. They should be directed to ensuring safety, not just seen as a method of punishment and penalties.

Senator BOYCE—I want to go back to the suggestion from the Dental Association around the composition of the boards. Were your state branches consulted on that and did they agree that the idea of professional representation rather than jurisdictional representation was the way to proceed?

Dr Hewson—No, I think that was another thing that came out at the last minute. But I know that at least one dental board has also expressed that same view formally and I know other—

Senator BOYCE—One of the state dental boards?

Dr Hewson—Yes, and other state boards have also said that they agree with the position that we have put. But the only formal letter that I have seen in that respect was from the Northern Territory dental board. Of course others may have done, but I do not know about that.

Senator CAROL BROWN—I want to go back to your point about professionals tending to be harder on each other. My understanding of the public interest assessor is that if they believe a complaint is more serious then their view prevails, and if a board's view is that a complaint is more serious then their view prevails. Is that your understanding?

Dr Hewson—Yes, it is. I guess that is why we have said here today that we believe it is really important that they work to the same criteria so that they can actually compare apples to apples, not apples to pears.

Senator CAROL BROWN—Thank you.

CHAIR—If there is anything else that you think we should know, please get in contact with us. We are part of the whole process of consultation. I know you are talking with Dr Morauta and her group, Mr Boyd-Boland, but we would appreciate a copy of your next round of information so we can keep abreast of this.

Mr Boyd-Boland—Happy to do so. Thank you.

CHAIR—Thank you very much.

Proceedings suspended from 12.21 pm to 1.13 pm

DALTON, Ms Ann, Director, Government Relations and Policy, Pharmacy Guild of Australia

LIAUW, Mrs Judith, President, Tasmania Branch, and National Councillor, Pharmacy Guild of Australia; and Vice-Chair, Pharmacy Board of Tasmania

PHILLIPS, Ms Wendy Margaret, Executive Director, Pharmacy Guild of Australia

TODD, Mr Ian Philip, National Councillor, Pharmacy Guild of Australia

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mr Todd—I am also the president of the South Australian branch of the Pharmacy Guild.

CHAIR—Some of you have given evidence before, so you know about parliamentary privilege and the protection of witnesses. Thank you very much for your submission. To clarify, your submission refers to the bill in the first round and has not been updated since the second communique, the May communique.

Ms Phillips—That is right. We have to put in a supplementary submission.

CHAIR—That is fine. Things have changed a bit, but people still have key issues. I just wanted to confirm that your submission refers to the original bill.

Ms Phillips—Yes.

CHAIR—I invite any or all of you to make an opening statement. Ms Phillips, are you leading off?

Ms Phillips—On behalf of the Pharmacy Guild of Australia I would like to thank the committee for the opportunity to address you on this important matter of registration and accreditation of health professionals in Australia. The guild, as you would be aware, represents pharmacists who are the proprietors of community pharmacies. There are almost 5,000 community pharmacies spread across Australia, and the guild has branches in every state and territory.

Let me first say that the guild supports having national registration of health practitioners—in our case pharmacists—and believes it is an essential step in facilitating workforce mobility. That said, the guild has some reservations about the manner in which the new scheme is being developed and implemented. I will go through the three main areas of concern that we have.

Our first concern is that a regulatory impact statement for the proposed national structure has never been published and in fact it seems that the costing of the scheme has not been fully analysed. This is unlike the COAG coordinated National Licensing System for Specified Occupations, which published not only a regulatory impact statement during the scheme's

consultation stage but also a final regulatory impact statement in April 2009 prior to the finalisation of the intergovernmental agreement establishing the national scheme. I have a copy of this regulatory impact statement, which I wish to table. It is called the *National Licensing System for Specified Occupations: Decision Regulation Impact Statement*.

With regard to the cost of the proposed scheme for health professionals, we are concerned that the administration of the scheme, including the salaries paid to officials employed for this purpose, will have to be paid by the registration fees of health professionals but that the professions themselves have no control over these administration costs or their potential increase over time. We believe this should have all been determined and made available to the professions in advance of the legislation being finalised.

Our second concern, which links to the first, is the unnecessary haste with which the legislation is being finalised—legislation that will determine the way in which Australia's health professions will be regulated for the foreseeable future. There are only five weeks allowed for consideration of the draft legislation—that is, bill B. The guild has provided comments on the bill. These will be attached to our supplementary submission to this committee that will be lodged by 24 July. We urge this committee to recommend that an appropriate parliamentary committee, either this committee or a committee of the Queensland parliament, which is the host jurisdiction for the national law, carefully examine the legislation before it is passed in that state.

The third area we want to touch on is perhaps the most important from our point of view. The guild believes there is a better administrative model that could be used for the scheme, a minimalist cooperative reform model. For pharmacy it would create a national pharmacy board, having representatives on the board of each jurisdiction, to approve national registration and accreditation standards following policies developed by the Australian Health Workforce Ministerial Council. That is probably similar to what is in the scheme but the difference is that we would like to see retained the state and territory based pharmacy boards, which would perform the initial registration and subsequent discipline of practitioners. This would be similar to the national delegated agency model approved by COAG in the same scheme I referred to earlier—the National Licensing System for Specified Occupations—because it creates a central agency to establish the national licensing policy but retains the existing agencies to perform the registration and enforcement responsibilities.

With regard to pharmacy, 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. It is very difficult in the case of pharmacy to take one out without looking at the other.

With regard to this same specified occupations scheme both a singular agency model, like the one that has been proposed for the health professionals, and a delegated agency model were

tested and the decision regulatory impact statement as specified on page 20 agreed that the advantages of the delegated agency model were that:

... it minimises the risk of disruption in the transition and initial implementation phases for all stakeholders while providing opportunities for the identification of further reform once the national licensing system has been established. It reduces the initial costs of establishing the new system and maintains the benefits of integrated operational functions at the jurisdictional level.

It became a kind of transitional approach to putting the new scheme in place.

In summary it is a basic tenet of regulatory design that any benefits of a proposed reform must outweigh the cost of implementation, but it is not immediately clear to the guild that the costs of dismantling the current system of state and territory pharmacy boards and creating an entirely new bureaucracy passes this test. The guild would ask this committee to recommend that the proposed national scheme not proceed until the regulatory impact statement or cost-benefit analysis prepared for the scheme is published and that the costs and benefits of the guild's proposed minimalist cooperative model for pharmacy is analysed. The guild's view is set out in greater detail in both our original submission to the committee and the supplementary submission which we will provide shortly. Obviously, we would welcome any questions about the important role played by the pharmacy boards in the current system and the problems we see for pharmacy if the national scheme in its current form is adopted.

CHAIR—Does anybody else have an opening statement?

Mrs Liauw—No.

CHAIR—Ms Phillips, can you just tell us how long the consultation has been going on this proposed change.

Ms Phillips—The consultation period has been going for quite a long time and we have had all sorts of discussions, particularly leading up to part A. Where we feel consultation has been very limited was that, once part A was made available, all of the professions only actually got a chance to look at that really after it had been finalised. So there was no ability to look at the draft. In the case of bill B we only have five weeks. Once again, our concern is that none of this goes to the detail of, for example, what the actual scheme is going to cost and how it is going to be paid for. All of the professions said right at the beginning that they were really nervous if they had no control over how the administration of the thing would operate and whether or not they would have an impact on what the professional fees would be for each of the health professions and whether the fees would increase as costs went up.

CHAIR—Have you raised this with the government?

Ms Phillips—Yes.

CHAIR—And the response?

Ms Phillips—We have had discussions regularly but it has always been said, ‘This is the detail that will come later.’ We feel it is fairly fundamental to the scheme itself to have some sort of business case developed so that we have some idea of what the costs are likely to be.

Senator BOYCE—You have mentioned, Ms Phillips, that you will be putting in a supplementary submission around bill B. Has bill B addressed many of the concerns of the guild?

Ms Phillips—I might pass over to my colleagues but we have dealt here mainly with the registration issues. On the accreditation side we are still unsure about whether or not the professions will be, in fact, setting their own accreditation standards or whether they will be imposed externally. We have always argued that the professions should be able to self-regulate as far as standards are concerned. That was one issue. The other issue I would go back to is costs and, no, nothing has been provided.

Mrs Liauw—I would like to add a little bit to that. One part that is in bill B is that it will be up to the national boards to decide whether or not there are state committees. As I said before, I am from Tasmania which is one of the smaller states. One of our issues and concerns all along is that there will not be that local representation and knowledge that has been there in the past to be able to handle issues to do with informal hearings or whether or not they even become hearings. The issue of cost is borne out in bill B by actually saying that it is going to be the cost to the national board whether or not it decides which states will have a committee belonging to that profession. So I think that is again the cost issue which puts particularly the smaller states, but maybe even states like South Australia, at a risk of not having a board of the particular profession to be able to give guidance back to that community which we have done in the past, as I said, on the pharmacy board.

Senator BOYCE—So your concern is that the way the costs would be worked out would mean that each state would be responsible for its own state committee costs.

Mrs Liauw—I do not believe the states are willing to bear that cost. I think that they are—

Senator BOYCE—But perhaps professionals in the state would be responsible, or something. Is that what your concern is?

Mrs Liauw—I am concerned that there will not be representation—that it will be costly and considered not to be important and that there will not be any representation within the state at all.

Senator BOYCE—Because no-one is advocating at the national board level for this to occur.

Mrs Liauw—Exactly. And they do not have the funding because it has all gone to the higher bureaucratic level, which is going to be above the boards—to this national management agency, which has not been something that the professions have had to fund in the past. That seems to be something they are going to have to fund in the future.

Senator BOYCE—Is the Pharmacy Guild a member of the professions reference group? I understand that the Optometrists Association has been—

Ms Phillips—Yes, we have.

Senator BOYCE—So you have been involved in the discussions with the group?

Ms Phillips—Yes.

Senator BOYCE—It would seem that in some areas you are less in favour of the scheme and have more concerns about it than some of the other professions. Would that be a fair summation?

Ms Phillips—I might just start off. I do not think so—not in terms of the actual scheme. What we are concerned about, though, is what is left behind. We are concerned that if there had been an ability to leave the boards in place the boards could service the scheme but also keep half their functions separate from the scheme to service the existing requirements at a state and territory level with regard to pharmacy premises.

CHAIR—But that only relates to pharmacies?

Ms Phillips—Yes.

Senator BOYCE—That was going to be my next question. I meant that some other groups have come up with other things. For instance, psychologists have mentioned psychologists who do not provide health services as being a one-off sort of thing. So this is the ‘out of the ordinary’ part for the Pharmacy Guild.

Ms Phillips—Yes, you are correct.

Senator BOYCE—You have recommended that the existing system continue to function for, I think, the transitional period of a couple of years alongside a new national system. Can you explain to me how you would see that as working?

Mrs Liauw—One of the papers that we are going to present to you on the 24th is about the minimalist model, which takes into account the national licensing system and the way it has worked. There is national registration of the particular professions under this system, but the existing state boards or committees are retained.

Ms Phillips—Yes. In other words—

Senator BOYCE—Is that indefinitely or is that a transitional move as far as you are concerned?

Ms Phillips—You would do it as a trial to see how it worked, and if it were successful and if it enabled funding to be retained to make these boards operational then you might keep them. 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. Therefore, whether it is transitional or whether we change over, I think it

will be a trial period. If it works efficiently and effectively, and cost effectively for the smaller jurisdictions, then it might be able to be kept permanently.

Senator BOYCE—Currently is state registration of pharmacists and of premises consistent nationally?

Mrs Liauw—No, it is different in each state depending, I think, on the number of registrants per state. I do not know whether Ian wants to give some South Australian information.

Senator BOYCE—What do you mean when you say ‘the number of registrants’?

Mrs Liauw—New South Wales has a lot of pharmacists, so I think they have lower fees, whereas Tasmania does not have very many, so—

Senator BOYCE—So the fees are different.

Mrs Liauw—Yes.

Senator BOYCE—But what about the requirements for registration?

Mr Todd—That is not the same in every state either. Most states have premises legislation, but not all. South Australia does, and we have fought fairly hard to make sure that stayed in our act, because we believe it is important that a premises is fit for its purpose. So the board has the power to come down and make sure that you have the proper textbooks and the proper measures and equipment for making creams and ointments; that the dispensary is of a certain size; and that you have a proper sized narcotics safe to keep those things locked away with only access by the pharmacist, who must carry the keys on them at all times. They are the sorts of things that go hand in hand with premises legislation. As Wendy said, it is very difficult in our particular profession to separate out what the pharmacist does from the building they do it in. It goes to the very heart of what we do and is about where we store medications—some being in public access, some away from public access, some under lock and key—and so on. That all forms part of the requirement of our state pharmacy act for the premises to be registered. We believe making sure those things are done is an important public protection.

Senator BOYCE—So that works in with poisons legislation, TGA legislation et cetera.

Mr Todd—Yes. That is not the same in every state, though. Some states do not have premises legislation.

Senator BOYCE—We are discovering that through another inquiry at the moment.

Ms Phillips—It is not under the poisons legislation but under the state pharmacy act.

Senator BOYCE—So that we have a sense of what is outside this, which states have registration schemes for premises?

Ms Phillips—All of the states with the exception of Queensland, and the territories do not. In other words, five states do.

Senator BOYCE—What are the consistencies or inconsistencies within those registration programs? Are they primarily consistent?

Ms Phillips—They are fairly consistent. Things like separate access to the public and storing medicines in a certain way would be fairly consistent.

Senator BOYCE—But they all give a voice to state laws, not to a national law.

Ms Phillips—Yes.

Senator BOYCE—There are two recommendations 5 on page 3 of your submission. I am interested in the second recommendation, which is that complaints and disciplinary matters continue to be heard at the state and territory level. That is a proposition which has been put by a lot of people. Are you suggesting that this should be based on state health complaints law or that there should be a national law administered at a local level?

Ms Phillips—We are in agreement with the system whereby the complaint can be lodged either through the national database or at a local level through the state. But, whatever happens, we think it must be then dealt with at a state level. That is our understanding of how it would work. Once again, we think that the boards as they are would be eminently capable of dealing with those complaints, because they have a lot of background.

Senator BOYCE—If this legislation goes through, what premises registration concerns would you have?

Ms Phillips—That is what we are very unsure about. It depends 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.

Mrs Liauw—We have had discussions around that issue in Tasmania, because our act incorporates both pharmacist registration and premises registration. It would be difficult to pull the pharmacist registration parts out and leave the existing act still making any sense. It would need to be redone, with all the issues relooked at. From the state perspective, they would expect the profession to fund whatever would need to be done to manage it. We are not a big state, as Carol knows!

Senator BOYCE—Are there any other health professions that are covered by this legislation that have premises registration legislation, to your knowledge? This is the first time this has been raised with us.

Ms Phillips—I do not think so because pharmacy is really the only profession that is carried out in a retail environment.

Senator BOYCE—What are your primary concerns about continuing the premises registration?

Ms Phillips—I suppose that our most important consideration is that we have fought so long and hard in the public interest for maintaining pharmacists' ownership of pharmacies, which is covered under that legislation. Then, with all of the other aspects around pecuniary interests and the registration and the standards within the premises, we would want to make sure that they are all kept just as they are. The problem with opening up legislation is that wording can be changed and things can be lost.

Mrs Liauw—We have found that it has been in the public interest before that the pharmacy premises are owned by pharmacists, who have the interest of the health of the patient at heart, and not by corporates, who are just looking at trying to make money.

Senator BOYCE—Presumably, then, the health and safety issues that you mentioned around storage and so forth are a secondary consideration, along with the other ones.

Mrs Liauw—Yes. There are standards involved with that. The Quality Care Pharmacy Program has standards around the business of the pharmacy premises and how it practises and the board currently takes these into account. That ensures that the public are getting a standard of care across community pharmacy, no matter where they go.

Senator BOYCE—Ms Phillips, you mentioned the fact that there had been no costings done on NRAS. Why do you think that might be?

Ms Phillips—Why has it not happened? It is possible that there have been costings worked out within departments, but nothing has been made available to the health professions. I do not actually know if it has been done—whether a business plan has been developed. It is something that we have raised before but, as I said, whenever that has been raised it has been put on the basis of 'Look, let's get the scheme in place first and then we will work out those details later.' But given the fact that the scheme has to be self-funding and therefore it is the registration fees of the health professionals that have to cover the costs, it is pretty intrinsic to the model, I think. In business you would never go into something without working out the costs.

Senator WILLIAMS—You would want to know the costings you are going to face in your industry before you are actually faced with those costs.

Senator BOYCE—Would you be able to supply us—probably on notice—with a list of the current registration costs in each state for pharmacists and for premises.

Ms Phillips—Yes.

Senator BOYCE—Or a general description if it is a very complex formula.

Ms Phillips—I think it is fairly straightforward.

Mr Todd—It is pretty straightforward.

Senator BOYCE—That would be helpful.

Senator CAROL BROWN—I want to touch on registration fees. Can chemists practise in other states if they are registered in Tasmania at the moment? Can they do it across the board?

Mrs Liauw—No. Currently they need to register in each state in which they practise. I have registration in Tasmania and also in Victoria at the moment.

Senator CAROL BROWN—Do you pay two sets of registration fees?

Mrs Liauw—I do.

Senator CAROL BROWN—Under the proposed scheme, what would you need to do?

Mrs Liauw—I would have national registration by paying one set, which I do not think we disagree with. That in itself is quite a good concept; it is just what happens around it.

Ms Phillips—If you just had a pharmacy in the one state, we are not sure whether you would pay the same registration fee as if you had a pharmacy in three or four states. Again, we are not sure of that. Whether or not that is something that would be determined by the national pharmacy board or each of the national boards, I am not sure. Again, none of these things have been looked at.

Senator CAROL BROWN—As I understand it, registrations are for practitioners, so if, as you said, you register once you would be able to practise across Australia.

Mrs Liauw—Yes.

Senator CAROL BROWN—I want to touch on the boards and the membership of the boards, and I hear what you are saying about jurisdictional membership. Did you consult with your members when you came to that position?

Mrs Liauw—As in the pharmacy owners?

Senator CAROL BROWN—The Pharmacy Guild as a whole, which you represent here today. Have you in the guild discussed your position of there being a member of the board from each jurisdiction?

Ms Phillips—Yes, we have. Currently, there is a board in every jurisdiction and, because there have been differences in the way premises have been looked at, we felt it was important to have a representative from each board.

Mr Todd—There are also some slight practising differences between the various states. For example, South Australia was the first state to have mandated that for pseudoephedrine sales, for example—which people like to misuse and make speed and things out of—you had to actually record the name and address of the person who was purchasing it and label them appropriately. Things do change from state to state, depending on where problems pop up from time to time in one state compared to another, which then flows through to the rest of the states. Having

representatives from every jurisdiction would help move those things forward more quickly. Rather than it being a slow process there would be that meeting of minds at the national level that could implement those sorts of policies reasonably quickly.

Senator CAROL BROWN—So it is a feed in of the local knowledge and experience?

Ms Phillips—Yes.

Senator CAROL BROWN—I just want to go back to the state legislation. As I understand it, legislation would have to be put through each of the states and territories. I am just talking about Tasmania at the moment but, with respect to the bits and pieces that were left behind, is your concern more about opening up that discussion we had a number of years ago about where chemists can operate and who can operate pharmacies?

Mrs Liauw—Definitely. Our concern is about that and all the issues that we have faced in the past. Also, we have concern about how we manage and what legislation sits around that and who manages that for the future. I think it could be expedient, for instance, if there was a state board in Tasmania. They could, more or less, have two hats—one which looks at the pharmacist registration issues under the national board and, two, which actually looks at any issues around the premises which may need inspections et cetera from time to time. There could be ways of making things happen in a small state that does not necessarily have to happen in a large state.

Senator CAROL BROWN—Are you saying—I might not have understood you—that with the national board and where they set up and appoint a state or territory based board that that board, other than dealing with registrations and complaints, would also deal with those issues about premises?

Mrs Liauw—Yes. I am saying they could have like a dual role. Under the national board it would only be funded to provide the service under the one role but then the registration fees from the premises could offset that additional cost of having a second meeting in the latter part of the day or whatever. You still have that area of knowledge that is actually not lost. I think, particularly from a Tasmanian perspective, that is our main concern, that in assessing the profession's role and protecting the public we will lose the knowledge of the people who are now there.

Senator CAROL BROWN—And the appointments to that state board are made, I think, by the state minister. Is that your understanding?

Mrs Liauw—Currently they are, yes.

Senator CAROL BROWN—Do you know whether that is the case under bill B?

Mrs Liauw—I think there are a few models being talked about at the moment. I do not think they have actually discussed the full impact of what will happen, but one of them did have the state minister involved in some part of the process. I think one was part of the national board having some say in it as well.

Senator CAROL BROWN—What would be your preference?

Mrs Liauw—I think there could be a combination. The state minister currently being involved has worked quite well and having a local knowledge of the state and what is happening, I think, has always been very important. I think the main concern I have about bill B is that it is up to the national pharmacy board whether or not it puts a committee in the state at all. I think that is an issue that is based on cost and it is one of the risks. That is the reason why we need to know that all the costs are not going to go on the high-level administrative stuff that will come onto the ground where we really still need the people.

Ms Phillips—And if the board were kept like that—with half of the functions going into the national scheme, with all of the money for that part going into that scheme, and leaving the registration of premises fee for the activities around that—it would be much more cost effective than having to set up a brand-new body.

Senator FURNER—I understand from the recent data that I have seen that there were around 17,000 full-time pharmacists in 2006. Is there any recent data on that at all or is that the contemporary data that is out there?

Ms Dalton—That would be the recent data.

Senator FURNER—How many of the 17,000 pharmacists may have been from overseas? Do you have an estimate?

Ms Dalton—We could certainly take that question on notice and provide an answer.

Mr Todd—In South Australia I am not aware of too many that are registered from overseas. There is a particular process they need to go through, and I could not think of probably half a dozen.

Mrs Liauw—In Tasmania we only deal with a couple a year who come from overseas through the APEC process, and that comes through the pharmacy board. I do not think there is a high portion in our state, but we could get back to you.

Senator FURNER—So there is no issue with accreditation or training of those people generally?

Mrs Liauw—There is a very good process already in place, which I believe will continue.

Senator FURNER—You seem to support in your submissions the proposals for the complaints management and disciplinary processes. Are there any issues that you can identify that you would like to indicate to us?

Mr Todd—We would certainly like to see those functions dealt with at a local level. I would not like to see it become very bureaucratic and by necessity involved legal representation from the word go because there was no local representation that could deal with those things. That would add to the costs of the pharmacists and then through their insurance and so on and then add costs to the national organisation as well because having to answer legal letters requires legal representation on the other side as well. We believe that should be held locally.

As I expressed before about pseudoephedrine being recorded in South Australia, some of those local issues need to be handled with some sympathy. When we had to start recording, for example, there were a few mixed messages about the way the legislation was written in South Australia and some pharmacists were only recording single ingredient pseudoephedrine products and not combination products. People we report those sales to spoke to the board and then the board visited the practitioners and said what the legislation said and told them to tidy up the way they were recording those things. Some local knowledge is really important rather than being a bureaucratic approach to that type of process.

Within a very short space of time the practitioners who had misunderstood their requirements were brought into line. I do not know that that necessarily would be the case if a letter came from Melbourne to my pharmacy and said: 'It has come to our attention that you have not been meeting your requirements.' Often for those minor practice issues those personal relationships with the board are much more helpful than a letter from a department.

Ms Phillips—One thing that was said by the boards in some of the earlier consultations was that a lot of work done by boards is often done at a voluntary level and a lot of the initial complaints can be dealt with very quickly without having to even get into paperwork because they can be handled by a quick phone call. They were concerned about it as a process becoming too formalised and bureaucratic and, as any Ian was saying, going to a national level and complicating the system when stuff could be dealt with easily. My understanding from what we have been told is that, although the complaint might be lodged either locally or nationally, it would then come back to the board or the committee to be dealt with at a local level. I am hopeful that that is the system that is intended.

Senator FURNER—Mr Todd, other than the example you used with products as an issue in dealing with complaints, what would be a general dispute or disciplinary matter to deal with pharmacists?

Mr Todd—I do not sit on the pharmacy board but I have sat in as a proxy on a couple of occasions. With our pharmacy board, once the general meeting has finished, a panel of people volunteer, if they have the time, to listen to any complaints that the board may have received. The last one I was at there were a couple of dispensing errors that members of the public had written to the board about. We sat around as a panel of four, I think, plus the registrar and had a look at whether there was likely to be some sort of fundamental problem with the way they go about dispensing in their pharmacy, for example, as opposed to a mistake that can happen to anyone.

So you have a little peer review of that incidence at a local level by practitioners who work every day in their pharmacy and then they direct the registrar as to whether or not they feel that the person needs to be dealt with by letter saying, 'We've received a complaint; I suggest you contact the person and apologise or whatever and we will write to them as well and say that we have spoken to you' or 'You need to come and speak to us; there is a formal panel that deals with those sorts of things.' Some things can be dealt with sympathetically if it is of a more minor nature but, if it is indicative of poor dispensing practice, for example, it goes through the full process of inviting you in and then sitting before the disciplinary panel and explaining your actions before they decide how they might go about encouraging you to improve your general practice.

Mrs Liauw—I would like to support what Ian says. I am on the pharmacy board, as I said, and we often have informal hearings. We have a separate investigating committee that sits similar to the panel that Ian was just describing. If they feel the practitioner needs to come before the board and explain what happened with a particular issues, they do. They give their version of the story and we have the complaint in writing from the person that it occurred to. We then look at the reasons behind why the error happened in the first place. We look at whether they did not use a scanner or accidentally picked the wrong thing off the shelf. We look at the issues surrounding it and suggest ways to improve their practice so hopefully the error does not happen again. So it is an educative thing to try to diminish the number of errors that are going to come before a board in the future.

Senator FURNER—Has there been an increase or decrease in errors as a result of the inception of, to use the terminology, ‘pharmacy assistance’, whereas before there was the pharmacist and the retail—

Mrs Liauw—I do not believe that it is easy to draw a line to say what the reasons are that we happen to see things before the board. I think pharmacies are getting a lot busier, but we are putting in place more checks to make sure that the process is better. For instance, in Tasmania, it is now mandatory that you scan the product that you take from the shelf and compare it with the dispensed label. So that is a second check that you have in place. Plus we are constantly writing out in our circulars to encourage pharmacists to talk to the customers about their medication, to provide counsel on the new medication and give them some information leaflets et cetera. Through communication they can often pick up problems with the way the patient is dealing with the medication. They are things that the local boards do on a regular basis that may get lost in this new process.

Senator WILLIAMS—Mr Todd, I would like to go back to the point you raised about South Australia and when people are buying certain types of substances you have a register of the name and address. Do you call for ID when you get those names and addresses?

Mr Todd—Originally we did not. About seven years ago we were the first state to introduce mandatory recording and labelling of those products, but now it is also a requirement that you have photographic ID.

Senator WILLIAMS—Very good. My concern was how we ensure that the details are correct if people just give a name and address.

Mr Todd—In every state, pharmacy boards encourage pharmacists to use what we call ‘project stop’, which is real-time tracking of the identifying number that you might present. It might be a drivers licence with a six-digit number which we put into our recording in real time. It checks whether that number has been presented in, say, the last 10 days. It does not say where; it just gives you the postcode and whether supply was made or denied. It is just another tool that we have at our beck and call to see whether or not our clinical judgment about supplying these things can be backed up. People can be very devious, as I am sure you are aware.

Senator WILLIAMS—Yes.

Ms Phillips—That is to prevent the illicit diversion of products like pseudoephedrine for clandestine labs. Project stop is a system that we have used to work in with police in various states.

Senator WILLIAMS—Ms Phillips, regarding the NRAS program, you are adamant in saying:

Standards must be developed and approved by the professional Boards. The role of the Health Ministers would be simply to endorse the standards.

Do you think that is a vital part?

Ms Phillips—Yes. We really feel that in pharmacy we have a very robust system in place in terms of standards. We absolutely support making sure that the standards are national, but the processes that are in place on that accreditation side seem to me to be very robust and we think that that works well when the profession is self-regulatory in that sense rather than having government coming over the top.

CHAIR—Thank you very much. You were talking about presenting an updated submission to us. It does not go to us; it goes to Dr Morauta's team. We will certainly look at what you have said, but we will not be reviewing this legislation again. This is your chance—I want to make that really clear. But we can always take more comments.

Ms Phillips—So if we wanted to we could feed in some supplementary comments to you?

CHAIR—Absolutely. We scheduled these hearings to fit in with the existing consultation period through the Dr Morauta process so you were not doing it twice. Thank you very much.

Ms Phillips—Okay. Thank you.

[1.57 pm]

BROWN, Ms Krystina Kaye, Chief Executive Officer, the Chiropractors Association of Australia (National) Ltd

EATON, Dr Sharyn, CAAN National Board of Directors Education/Registration Board Representative, the Chiropractors Association of Australia (National) Ltd

RICHARDS, Dr Dennis Milverton, President, the Chiropractors Association of Australia (National) Ltd

CHAIR—I welcome representatives from the Chiropractors Association of Australia. We now have your updated submission. Do you wish to make any comments about the capacity in which you appear today?

Dr Eaton—I am also president of the New South Wales registration board and head of Macquarie University chiropractic school.

Dr Richards—I am also a practitioner.

CHAIR—In which state, Dr Richards?

Dr Richards—In New South Wales.

CHAIR—When people are here nationally it is nice to know which state they are registered in. Are your two representatives who are chiropractors both from New South Wales?

Dr Richards—Yes.

CHAIR—Okay. We have your submissions. Is this an updated one that you have given us today or the same one?

Ms Brown—No, it is not updated.

CHAIR—The reason I ask is that we had a number of submissions that came through before the release of bill B. Was this one written before bill B?

Ms Brown—Not to this inquiry.

CHAIR—That is fine. So you could well have amendments to that one?

Ms Brown—We are actually referring to bill B in the discussions today.

CHAIR—Fantastic. I invite any or all of you to make some opening comments and then we will go to questions.

Ms Brown—I can give a brief background on that submission to save you reading it.

CHAIR—That would be fine. Thank you.

Ms Brown—We represent the Chiropractors Association of Australia, which is in the peak body in Australia representing chiropractors. There are 2,600 members in our association. This matter is in regard to restricting the practice of spinal manipulation in legislation relating to the new national registration and accreditation scheme, and in particular to regulation 137 of the exposure draft of bill B—the Health Practitioner Regulation National Law Bill 2009. 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 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.

The CAA is of the view that spinal manipulation should be a restricted practice and that any person performing the manipulation of any part of the spine must be either a registered chiropractor or osteopath or a registered health practitioner who can demonstrate equivalency of competence by appropriate, accredited, prescribed and clearly identified postgraduate training. The CAA asserts that citizens face significant risks which could result in serious injury to them if they were in the hands of unskilled, unregulated persons performing spinal manipulation.

The CAA lodged a submission to Dr Louise Morauta's group. However we were never consulted regarding the recommendations that we put forward and nor were we consulted to provide comments in the development of the wording of bill B. This was despite the fact that chiropractors undertake five years of university training. As a prerequisite to registration to practice they must have completed five years of university training. They are primary-care practitioners who have specific, comprehensive and specialised skills in the manipulation of the spine and its extremities—including the identification of indications and contraindications as well as the highly-skilled delivery of therapeutic intervention to and about the spine, taking account of the patient's age and clinical presentation. So that just gives you a bit of background.

CHAIR—Ms Brown, every time I begin to think that I have got a handle on this it just slips away. In terms of process, by this change of wording in this bill who do you think will now be able to do the work that you strongly believe in your professional knowledge should be limited to the group that was originally in the bill?

Ms Brown—In six out of the eight states and territories in Australia it is currently a practice restricted to medical practitioners, osteopaths, chiropractors and physiotherapists. Bill B is suggesting that neck manipulation only—not full spine—will be restricted to those four practitioners.

CHAIR—And who else can have a go at you whole back then?

Ms Brown—Anybody.

CHAIR—So there are no limitations. Are you aware of any lobbying from any group that would be pushing for that extension?

Ms Brown—Do you mean pushing for it to be unrestricted?

CHAIR—Yes, unregulated.

Ms Brown—Possibly the physiotherapists. In discussions with them around the consultation paper on registration they indicated to me that they were not pushing to have it restricted. They did not elaborate in too many ways as to why. That is one group that I was told—

CHAIR—So you have no idea where this change came from?

Ms Brown—No, except that I was in discussion with one of the policy advisers in Louise's team because we wanted to go and meet with them to discuss it before bill B came out. He suggested that it would be better if we waited until bill B was actually out and then, when we had read the full account of what the legislation was intending, we could make recommendations. We were told that they received legislative advice around the issue. They based their decision, as I understand it from what I was told, on the fact that there was no evidence to prove that if it was restricted, as opposed to unrestricted, there was any danger to the public.

CHAIR—I take it that you are taking up, through the processes of the Morauta team, strongly your position.

Ms Brown—Yes, we will be—and we did initially. We have not changed our stance.

CHAIR—No, but you are going to take it up now that bill B has been published.

Ms Brown—That is correct.

Senator BOYCE—I just wanted to follow up on that. Victoria and Western Australia do not have any restrictions on who can do what to your spine. Is that correct?

Dr Richards—Yes.

Senator BOYCE—Are you able to give us any statistics or information about the incidence of problems caused by spinal manipulation in those states compared to others?

Dr Richards—No, we cannot. There is no formal reporting mechanism for that. In submissions previously in this whole process we have listed quite a few references in the scientific literature of where this has happened in overseas jurisdictions.

Senator BOYCE—Was that in a previous submission to this committee?

Dr Richards—No, not to this committee.

Senator BOYCE—It would be useful for us if you could give us a copy of that information around the effects on public health.

Ms Brown—It is actually in the attachment to the submission.

Senator BOYCE—Do you mean the one we have just received?

Ms Brown—Yes, it is on the back.

Senator FURNER—On that issue that Senator Boyce has raised, that is listed in your submission. You have referenced that by indicating various names of persons. I am wondering whether you can elaborate further on that to allow us to access it via the Internet if that is at all possible.

Dr Richards—Are you referring to the papers?

Senator FURNER—Yes, that is right.

Dr Richards—I am just looking for it here in the submission. I think the whole citations for those papers are in here.

Senator BOYCE—Yes, page 27 seems to have full citations.

Senator FURNER—I am looking at page 8, where you have identified some cases where people have been incorrectly manipulated.

Dr Richards—The full citation of those papers is there and that would be the way to track them down.

Senator FURNER—That must be in subsequent papers beyond page 8.

Senator BOYCE—As you point out here, it is mainly relating to overseas jurisdictions. But we do have two states where there are no restrictions. I note the comment you make about the difficulty of complaining, but for the record could you please explain why there would not be a body of evidence from Victoria and Western Australia supporting your contention.

Dr Richards—Because someone would have to gather that information and put it together in one place, and if a layperson was to injure a person in that way then who would report it?

Senator BOYCE—Who would they report it to? Most states do have—

Dr Richards—Who would the injured patient report it to? In terms of a patient injured in this way seeking recompense for this, they would have to take legal action against the person who provided the spinal manipulation. That would be, I think, a civil matter. If that was found to be, there is no body that records those sorts of events. Who would that be reported to?

Senator BOYCE—You would imagine that they might contact the health ombudsman.

Dr Richards—That might happen, yes. But there is no formal reporting mechanism.

Dr Eaton—I am the president of the New South Wales board. We are currently collecting data on injury with spinal manipulation. The literature in general is sporadic. It is there. However, and I am pretty comfortable in saying this, the data between states comparing states has not been done at this point. We are doing it in New South Wales currently and this is something we have undertaken recently with respect to national registration. Your comments and your concern is warranted but, as I have said, at this stage we have not compared states. It has a lot to do with where the schools sit as well. In Western Australia a number of years ago there was not a school. And there is no school, I think, in the other state, which is South Australia. So there are a number of issues in play here. It is early days.

Senator BOYCE—I thought it was Victoria and Western Australia that had no restrictions.

Dr Eaton—Victoria has got a school. I am not sure where the regulatory authority got their unrestricted position from, but I do not think it would come from the data—but I may stand corrected.

Senator BOYCE—What you are telling us intuitively sounds true, but I was hoping you might have something that you could back that up with.

Dr Eaton—Probably in a couple of months New South Wales will have something, and I will look into Western Australia and Victoria after this meeting.

Senator BOYCE—You have mentioned that masseurs, naturopaths or practitioners of Chinese medicine might undertake spinal manipulation if this legislation were to go ahead. What sort of damage might happen?

Dr Richards—There are all sorts of sources for what the risks are and what sort of damage can happen. I can give you the major ones from the World Health Organisation. The major ones in the lumbar region—and bill B proposes that this will not be restricted—are lumbar disc rupture; abdominal aorta aneurysm, or bleeding to death; and cauda equina syndrome. Forgive me if you already know this, but cauda equina syndrome is where the nerves at the very base of the spine are injured. Those nerves control, amongst other things, the bladder, the bowel and the legs. If you are unfortunate enough to have those areas damaged, and you have cauda equina syndrome, you are going to lose control of your bladder, your bowel and your legs. That is not a good way to be.

One point we want to make here is that, if persons who are not registered in any way, laypersons, are permitted to perform spinal manipulation and these types of injuries happen, the patient is then faced with perhaps needing support for the rest of their life to deal with the situation they are in. With registered healthcare practitioners, they are required to have \$10 million worth of PI insurance in New South Wales. That will cover that. If it is a layperson, it is very unlikely they would have any professional indemnity insurance, so how is the person to be supported for the rest of their life?

For the thoracic region, the major possible side effects are adverse events of rib fracture and separation of the ligaments between the ribs. In the cervical region—where it is proposed it is

restricted—they are much more serious. There can be paralysis of the diaphragm, which means you cannot breathe. There can be disc lesions in the neck, pathological fractures of the bones of the neck. The major risk is vertebrobasilar accident, which is stroke.

Dr Eaton—As the leader of an educational institution, I know we spend over 550 hours in the entire five-year program just teaching spinal manipulation, and other schools are similar because we are all under the same accreditation standards. In that practice, we learn the psychomotor skill, which is the speed of the adjustment, understanding how soft tissues feel and the specificity of adjustments but also understanding the underlying condition that the patient might have, such as arthritis, osteoarthritis, systemic arthritis, and whether we should adjust someone in those situations. Also, whenever we come across a problem—like a disc problem, which is a problem we are all aware of—we teach students what adjustments, what manipulations, to use to correct that area. We teach them specific manipulation or adjustment techniques for particular problems. Untrained people cannot understand that. With respect to the amplitude, depth and direction, it is quite involved. As I said, we spend over 550 hours doing it, so it is something we take very seriously. When a patient has a lytic problem from a neoplastic or a cancer problem in bone, the students know not to adjust, otherwise they will create pathological fractures. How would an unskilled person know that? We go through a lot of training, a lot of radiological studies, a lot of examination and so forth to make sure that students understand these conditions and they know what to do in those circumstances.

Senator BOYCE—What is the actual course—what length of course and—

Dr Eaton—It is a five-year program. All schools in Australasia have a five-year program. It is three years of a bachelor's degree and two years of a master's degree. They have to do the master's degree in order in order to practice and obtain registration.

Senator BOYCE—So it is three years of theory?

Dr Eaton—The theory and the practice are intermingled right throughout the whole program. The diagnostic, adjustments and manipulation stuff gets stronger as they go through the program. We start them off with very general skills. They learn what soft tissue feels like and how to move a joint and get to understand the function of the joint. If that joint is not functioning properly, they learn what to do to make it function properly. If that joint has arthritis, they learn what to do then. It is a huge area. I am amazed that making it unrestricted is even being considered.

Dr Richards—There are special skills for babies, paediatrics and geriatrics. One size does not fit all, either. The five-year full-time courses are just over 4,200 hours of face-to-face instruction.

Senator BOYCE—You also had some concerns about the fact that chiropractors are no longer specifically mentioned in dental manipulation. Is that correct?

Dr Richards—We understand that with regard to dental practice there may be some restrictions of practice there. We wanted to—

Senator BOYCE—And this has changed between the earlier information you had and bill B?

Ms Brown—This is bill B. My understanding—and it is not detailed—is that there has been some new clauses put in there in relation to dentists. Chiropractors—and I will need to defer to a chiropractor to explain this, because I am not a chiropractor—work with the jaw. In fact, they enter the mouth. It is something to do with the fact that they enter the mouth as to why the dental regulation came in. What we want to make sure that the writing in bill B did not restrict chiropractors from working on the jaw.

Senator BOYCE—The first submission we had from you said that the restriction inadvertently restrict chiropractors from undertaking mouth manipulation. Do you think that it is mistake that the bill precludes you from undertaking this manipulation?

Dr Richards—Yes.

Ms Brown—I know that the combined chiropractor registration boards are presenting to you later today and I am sure that they will bring this issue up in a much more technical fashion than I can.

Senator BOYCE—That would be a terribly useful thing for them to do.

Dr Eaton—Basically, it is well documented that the jaw can relate to the neck. There are a lot of muscles inside the mouth that affect the jaw. Sometimes, chiropractors need to go there. There is also a whole new area to do with cranial work. There is sporadic research on it, but the clinical benefits are enormous. That is another area as well.

Senator BOYCE—You also mentioned at an earlier stage a number of significant drafting errors in bill B. You have mentioned what you believe to be an inadvertent error here. Who have you raised those errors with at this juncture?

Ms Brown—Nobody.

Senator BOYCE—But you will be?

Ms Brown—Yes, we will be.

Senator BOYCE—You will be advising Dr Morauta's group of that?

Ms Brown—Yes.

Senator BOYCE—Does your submission to us outline all the errors that you perceive to be in bill B or not?

Ms Brown—No. We are particularly dealing here with spinal manipulation. But we will have a further submission in which we look at different aspects of bill B. That will be going to Louise's group. We felt that we had a certain amount of time and these issues, in terms of patient safety and chiropractors, were important. I am not suggesting that the others are not important, but this is our opportunity to put those things forward.

Senator BOYCE—I was just interested in your use of the term ‘errors’ and what that might involve.

Dr Richards—There is one matter that is very important to us. I do not want to interrupt you, but before we run out of time we would like to bring up one particular matter that we feel is probably the crux of the whole thing from our point of view. May I do that now?

Senator Boyce—Yes.

Dr Richards—We have two concerns here. First of all, the bill proposes restrictions on spinal manipulation. As we have just discussed, it proposes that only manipulation of the neck be restricted. From our experience, manipulation of the full spine should be restricted. We have just heard about the risks of lumbar and thoracic adjustment. We believe that that is important.

The other thing that we are very concerned about is that spinal manipulation will be limited or restricted to four professions: chiropractic, osteopathy, physiotherapy and medicine. For two of those professions, this is really their area. They do the five-year, 4,200 hours of training that focuses on this skill. That is what we do; that is what we exist to do. I do not want to make any comments on other professions except to present some information from the knowledge I have.

We understand that the physiotherapy profession has four-year courses at university level. In those, they mainly do physiotherapy, obviously. We understand that their training particularly focuses on mobilisation. Mobilisation is a much softer and gentler type of work on the spine and other areas. It does not require the high velocity thrust to take the joint beyond its normal range of anatomical motion, which is what we do. We understand that the physiotherapists receive some training in that but from what we can see on web sites the training is in the order of dozens of hours rather than thousands of hours. Just from the Latrobe web site, the information that we have is that they have a course in this area that is 75 hours long. It covers mobilisation and manipulation of not just the spine but also the extremities. It is very difficult to accurate information on this, but the amount of training in spinal manipulation in the physiotherapy profession—at least in this course—may be 30 or 40 years.

The medical profession have five-year undergraduate courses. Our understanding is that in their training they have no relevant training whatsoever in spinal manipulation. Our question is this: if they have no relevant training whatsoever, why are they excluded from these restrictions? That seems a very obvious question to us. I have a paper here from the journal *Australasian Musculoskeletal Medicine* from 2002 from the School of Medicine of Flinders University, Adelaide. I will read a couple of paragraphs. They read:

Deficiencies in musculoskeletal competence among general medical practitioners is commonly acknowledged. The degree of this deficiency is thought to be widespread.

... ..

Musculoskeletal knowledge among recent medical graduates has again been found wanting. The need for further musculoskeletal education has been established.

Our point here is that according to this paper they have deficiencies in understanding and knowledge of the musculoskeletal system anyway. On top of that, without any training whatsoever, they are allowed to perform spinal manipulation. That screams out at us.

Senator BOYCE—You remind me, Dr Richards, that I read a *Medical Journal of Australia* article within the last month or so suggesting that GPs who specialised in back problems had worse outcomes than GPs who did not claim to specialise in back problems.

Dr Richards—Yes, I read that, too. Thank you. I have a couple of other points on this. During this whole COAG process, we have presented evidence—and I want to make it very clear that this evidence is 20 years old and we do not know what the situation is now—about a judgment of the New South Wales Medical Tribunal in 1986 in the Bosanquet case. The medical tribunal expressed concern about the dangers of spinal manipulation carried out by practitioners without recognised expertise. This related to a medical doctor who performed spinal manipulation on a patient who subsequently died. I will quote the conclusions of the Medical Tribunal. They said:

To the extent to which cervical manipulation is carried out by unregistered and unsupervised persons, we can only say the prospect is frightening and the public should be warned.

That is from the New South Wales Medical Tribunal.

I want to go back 20 years in history. We have copies here of a correspondence course in spinal manipulation for medical practitioners. It is a 10-unit course. The first unit is on the page that I am indicating. The second unit is also one page long; number 3 is one page long; and number 4 is four pages long. Most of the units are between one and six pages long. Again, that is 20 years old. There are people practising spinal manipulation now who did a medical correspondence course accredited by the Royal Australian College of General Practitioners. We find that horrifying. We do not know where medical practitioners are learning spinal manipulation now. We certainly hope it is not in correspondence courses. There was an optional three-day, hands-on workshop in this course; you did not have to go if you did not want to.

We are not saying that we own spinal manipulation; we are not saying that other professions should not do it. We believe that in the interests of the public there should be a minimum standard. To do this we go to the New Zealand commission of inquiry into chiropractic, which sat for 18 months and investigated in New Zealand, Australia, Canada and the UK. They found:

Part time or vacation courses in spinal manual therapy for other health professionals should not be encouraged.

They said:

... to acquire a degree of diagnostic and manual skill sufficient to match chiropractic standards, a medical graduate would require up to 12 months full-time training ...

We do know that within the physiotherapy profession there is a group called ‘muscular-skeletal physiotherapists’, who do a postgraduate course in that. It is an extended course; it is one year/two years, full time/part time. We are arguing that we believe it is in the interests of the public that physiotherapists and medical practitioners who wish to perform spinal manipulation should have a minimum standard of accredited and recognised training in that skill—perhaps, in

line with the New Zealand commission's finding, a one-year full-time course or the equivalent two-year part-time course. We are stunned that the government, in terms of looking after the safety of the public, would allow medical practitioners with no relevant training at all to perform that skill.

Senator FURNER—We have heard from other witnesses in regard to the fulfilment of a shortage of practitioners in a variety of different fields where there is a need for overseas practitioners to operate. I imagine with the deregulation, if I can use that term, of the area of chiropractic accreditation that you have identified today in some areas that anyone could enter the country and set up a practice of chiropractic services down the road regardless of having any checks and balances on accreditation for that particular person. Would that be the case?

Dr Eaton—That would be the case if national registration brought in a lack of restriction to every area of the spine except cervical manipulation. Basically, the accrediting authority could examine them, but at the end of the day it is not a requirement. That would be quite frightening.

Senator FURNER—Would you have any examples of numbers or of people coming from overseas who are members of your association and have set up practices.

Dr Eaton—Sorry, your question is: how many people come from overseas to set up practice here in Australia?

Senator FURNER—Yes.

Dr Richards—We do not have an accurate number.

Dr Eaton—We examine quite a few of them at our university because they have to do an examination before they start practising in Australia. We would be examining around 20 to 25 per year. I would say that Western Australia would do the same. Maybe between 50 and 100 per year.

Dr Richards—These people have to be graduates of accredited chiropractic institutions from somewhere else in the world. A person without any relevant training cannot do that.

Senator WILLIAMS—At the moment accreditation is carried out under the state body; is that correct?

Dr Eaton—Accreditation is from the CCEA, which is not state; it is national. It is an Australasian accrediting body, which has standards that are linked with the international accrediting body. They accredit the four schools in Australasia. There are definite standards that we have to abide by, and all regulatory bodies in Australia use this accrediting body to help them ascertain who is qualified and who is not.

Senator WILLIAMS—Being an old shearer and a chiropractor's best customer—

Dr Richards—Great!

Senator WILLIAMS—I find it alarming when you talk about restrictions on those who can treat necks. I have spent a lot of time with a chiropractor in my life and, I might add, have had great success. To have an open slather situation because of some accident or misprint in the legislation would be scary.

Dr Eaton—Being on the registration board, I know we often get complaints about masseurs or untrained people cracking people's backs and those people ending up with a rib fracture or some pathological fracture. That is a real issue. As I said, we spend a lot of time teaching students how to recognise these conditions and what to do.

Senator WILLIAMS—It is a professional industry.

Dr Eaton—Yes.

Dr Richards—We see it this way. I flew down here this morning on Qantas. Flying is an inherently dangerous thing to do because of gravity.

Senator WILLIAMS—So is driving.

Dr Richards—However, there is a person up the front of the plane who has an incredible amount of training. They are the sort of person who, when the plane hits two geese in New York, has the ability to safely land that plane with no engines—

Senator WILLIAMS—In a river.

Dr Richards—in the river in the middle of New York. Flying in countries like Australia or the US is safer than driving your car. The reason it is safer is the high level of training that the people up the front have. Spinal manipulation is the same: it is inherently dangerous and you can limit that danger and make it a safe process, when you compare the benefits and the risks, by having people do it who are highly trained, who do five-year courses just in this; it is not a sideline. That is the way we see it.

Senator WILLIAMS—I have a final question, which may be relevant. Why do GPs not recommend to most of their patients that they go to chiropractors?

Dr Richards—I could ask you why Holden dealers do not recommend that their customers go to Ford dealers.

Senator WILLIAMS—Fair enough.

Dr Eaton—The answer is more political. I would say that a lot of GPs do not understand what we do. They do not understand the training that we do. I would happily debate any GP on what we do if they would debate with me, but they shut up shop immediately. I would say that most of the time it is due to the fact that they do not understand what we do.

Senator WILLIAMS—When the NRAS is established, are you confident of having enough representation on it?

Dr Eaton—Sorry, could you say that again?

CHAIR—Is your profession actually going to be well represented?

Dr Eaton—I am comfortable with the situation, but you bring up a relevant point: why do GPs not like us? I would debate with them any day as to why they do not like us if they would be prepared to do it.

Senator WILLIAMS—Sorry; I did not mean to promote an argument!

CHAIR—Dr Richards, I have not had a chance to read your submission in depth but I have skimmed the bits about the degree of practice that Dr Eaton has also referred to. My question is: do they do it now? We are looking at the new national registration and accreditation process, which is looking specifically at the accreditation each profession is required to have, the training they are required to do and the work that they are registered to do, in a partnership process. You have gone into great depth in your submission about the degree of training that is now available to people in different professions. My question is: in the current situation, do the people who are physiotherapists and GPs actually do the work that we are talking about; do they do spinal manipulation?

Dr Richards—Yes, they do.

CHAIR—You will be talking about a change.

Dr Richards—Yes, what we would be arguing for is that a minimum standard be set.

Dr Eaton—To do with training. We do not have a problem with physiotherapists.

CHAIR—I just want to get it really clear that some people—not all but some people in this profession—are currently doing the things that you are concerned about, so what you are doing is, under this process, looking at making a professional change.

Dr Eaton—Minimum standards.

Senator BOYCE—It almost sounds as though spinal manipulation has quite different meanings within different occupations.

Dr Eaton—It does.

CHAIR—I think also people would look originally at your submission and think you are concerned about alternative groups practising as opposed to other professional groups but then you do not believe the appropriate training is in their current schedule.

Senator FURNER—I am like my friend down the end there. I think it comes with my height. I visit the occasional chiropractor and other service providers for my back. I notice that in some cases their treatment blends into other types of treatment like naturopathy and acupuncture. Is there any regulation or accreditation involved with a chiropractor extending into those sorts of fields?

Dr Richards—Only, I believe, in the state of Victoria under the Chinese Medical Registration Act there. I think chiropractors may be excluded for that, but there is no regulation as such of acupuncture or naturopathy in Australia to my knowledge.

Senator FURNER—Do you have a view on the exclusion under the providers bill or should it be open for those types of treatment to continue?

Dr Richards—As for chiropractors to continue doing that?

Senator FURNER—Yes.

Dr Richards—Personally, I think anyone who does anything should have some minimum standard of training. There are not any set minimum standards of training to my knowledge. There are many different groups teaching acupuncture and, to my knowledge, there are no minimum standards set by the government. There is no minimum standard for naturopathy either. I would certainly be happy, if chiropractors were going into those areas, that there be a minimum level that they had to attain. I think it would be hypocritical if we were to say, ‘You have to meet a minimum standard, we don’t.’

Dr Eaton—Basically, chiropractors do best what they are trained to do. I believe naturopathy is going for registration. Basically, being on a registration board we do not condone all outside therapies. If you are a naturopath, that is not chiropractic. You go and see a naturopath if you want naturopathy treatment. We are profession specific. We have certain things that we do and we do not facilitate or encourage people to go out and do acupuncture or naturopathy and we do not recognise it, as a board, as chiropractic treatment anyway. It is certainly a good question because I know a lot of chiropractors do branch into other areas. It has to be proposed to the board that if they are going to do this type of treatment, whether it is acupuncture or naturopathy, they have to do a minimum amount of training. That is where we would sit on that because we have done it in other areas.

Dr Richards—Our professional indemnity insurance covers chiropractors practising acupuncture providing they have reached a certain standard of training.

CHAIR—It would almost be a prerequisite with insurance. If you do not have the qualification, you are not going to be covered. Thank you very much. We appreciate your time. I have just had a quick look at the board’s submission and recommendations and they are amazingly similar.

Proceedings suspended from 2.39 pm to 2.59 pm

HILLIS, Dr David John, Chief Executive Officer, Royal Australasian College of Surgeons**McADAM, Mr James, Director, Relationships and Advocacy, Royal Australasian College of Surgeons**

CHAIR—Good afternoon. Information on parliamentary privilege and the protection of witnesses is available to you. We have your submission; thank you very much. I invite either or both of you to make a short opening statement. We will then go to questions. This session is scheduled to go until 3.45 pm.

Dr Hillis—The Royal Australasian College of Surgeons thanks committee members for the opportunity to appear here today and for your consideration of the two written submissions made by the college on the subject of the proposed national registration and accreditation scheme for doctors and other health workers. The most recent of these submissions was made last week—I hope you have had the opportunity to quickly peruse that—and was in response to the exposure draft of the Health Practitioner Regulation National Law 2009, or bill B, as it has now become commonly known.

The college has been actively involved in the consultation process leading up to the release of the exposure draft of bill B. We have responded to most of the discussion papers released by the national registration and accreditation implementation group over the past 12 months, and the college has been in regular communication with the senior members of that group. The college considers the communique that was released by the Australian Health Workforce Ministerial Council on 8 May 2009 to represent a considerable improvement on the initial design for the national registration and accreditation scheme for health professionals. The college also views that communique as a public commitment from the ministers with regard to the future form of the legislation.

The exposure draft of bill B, while reflecting many of these improvements, does not enshrine all of the commitments contained in the ministerial communique, and we would welcome some opportunity to go through those issues this afternoon. As the bill currently stands, it offers only the possibility rather than a guarantee of improvement. Notwithstanding the occasional reference within the bill to wide-ranging consultation and the capacity of entities to publish dissenting views, the power of the ministerial council is rendered absolute by this bill. While ministers pledged to separate the registration and accreditation functions, the subsequent legislation ensures that the extent of this separation is at the discretion of the national board. Moreover, all members of the national board are appointed by government. Significantly, under section 10, subsection (4), the ministerial council can overrule both the national board and an accrediting authority if it considers there may be:

... substantive and negative impact on the recruitment or supply of health practitioners to the workforce.

Technically—and I would like to stress this—the recruitment or supply of health practitioners to the workforce is always an issue, so this clause could be readily invoked at any time. The possibility exists that politicians and public servants will seek to increase the number of health professionals simply by lowering the standards required to become a health professional. There

will always be the temptation under this scenario to put quantity ahead of quality. This is at odds with the undertaking given in the ministerial communique of 8 May, whereby:

The Ministerial Council agreed today that the accreditation function will be independent of governments.

I stress 'independent of governments'.

The college also notes the possibility that the legislation as it stands could result in the exclusion of specialist medical colleges from any role with respect to the registration, assessment, training or continuing competence of medical practitioners. Again it is significant that the ministerial communique of 8 May made specific mention to the specialist medical colleges and the Australian Medical Council. It is to be hoped that the legislation which ultimately passes through Australian parliaments does not preclude or undermine the ongoing work of these institutions. The college really sees no reason why the Australian Medical Council should not continue to accredit training courses and recognise medical specialties. It has been doing this for many years in a manner that is well regarded internationally. We see no reason to reinvent this wheel.

The college believes that this reform process should also be viewed as an opportunity to revisit the matter of areas of need and, in particular, the minister's existing power to declare an area of need without any consultation with the relevant profession. The college also has concerns regarding the protection of titles and the use of the terms 'specialist health practitioner' and 'medical specialist'. I particularly draw your attention to proposed section 134 of the draft bill. It is particularly confusing in its use of the words 'specialist' and 'limited'. Capacity for substantial confusion will exist in the mind of the public if the use of these words is not changed.

With regard to mandatory reporting, 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. With the mandatory reporting, we believe it is critical that a therapeutic relationship should also give exclusion to mandatory reporting activities.

The college also believes that proposed section 280 should include provision for bodies contracted to act on behalf of the national boards, such as specialist medical colleges, to be indemnified. Such indemnity currently exists in most regions of Australia and quite reasonably should be included in this important legislation as we move forward.

As a result of the series of forums that have been held over the past two to three weeks in most capital cities across Australia, it has become apparent that the national registration accreditation implementation group is aware of these issues and has stated that it intends to advise the Australian Health Workforce Ministerial Council to adopt at least some of the recommendations that I have articulated, that are in our submissions and that have been made by this college and other interested parties.

While this is welcome news, we still have to take a leap of faith. It is still the responsibility of the college to draw to the committee members' attention what we consider are still the deficiencies in the proposed legislation and also in what the 8 May communique had committed. The college believes that by incorporating the proposed amendments outlined in our submission

the Health Practitioner Regulation National Law 2009 could mark a genuine improvement in arrangements for the registration of health practitioners and a genuine improvement in the accreditation and training courses. Thank you very much for the opportunity to make this submission.

CHAIR—Thank you. Mr McAdam, have you anything to add at this stage?

Mr McAdam—No, thank you.

Senator HUMPHRIES—Dr Hillis, you mentioned that there were some areas where the minister's statements in the communique of 8 May had not been translated into the draft bill. You said that you were going to mention those. Could you do that now?

Dr Hillis—The particular areas where there are substantial gaps at the moment are in the ministerial communique 8 May under 'Independent accreditation functions'. It states:

The Ministerial Council agreed today that the accreditation function will be independent of governments.

It is a clear statement. Within the draft bill, the reporting methodology between the accreditation body and the national boards—and obviously the national boards are under the direct influence of the ministerial council—is very closely linked. There is actually no separation of those two activities. Consequently, we believe that, if everything were happening smoothly, perhaps there would be no problem; but, unfortunately, legislation also needs to look at the converse of that. At the moment, the control is still very closely and directly linked to that accreditation process. We believe it should be more formally separated and not be under the decree of the ministerial council.

Senator HUMPHRIES—How would you engineer that degree of independence? What would you do to provide that they were separate? You would have to have a relationship between the two and, presumably, the ministerial council would still need to have some oversight role. As the new structure in the bill was presented to this committee in a previous briefing, the boards are essentially determining the standards that have to be applied in registration processes and these are then shunted up to the ministerial council for approval. The approval cannot be refused unless the council has a concern about, as you mentioned, the supply or equipment of health practitioners to the workforce. Except on that ground, no other rejection of a board's decision can be undertaken. That is what we were told is the case. What greater independence do you think could be built into that arrangement to give real independence to the boards? Would you, for example, suggest that that exemption should be removed?

Dr Hillis—Certainly I think that exemption needs to be substantially watered down. There are two things here. One is the structural relationship. With our reading of the bill, there is still the capacity for the ministerial council to give specific direction to the accreditation body through the national board. We actually do not read it consistently with the way that you have been briefed, which is that the national board will give recommendation to the ministerial council, which will always accept it. In our reading of the bill, we are concerned that the reverse—that is, the ministerial directive—can still happen. That is the first point. The second point is that proposed part 2(10)(4) states that the ministerial council may give a national board a direction—they are quite literally the words in the bill—and—

Senator HUMPHRIES—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.

Dr Hillis—Yes. Our belief is that those words are always in power because there is a health force crisis at the moment. It would be relatively easy for the ministerial council to say, ‘We believe that the standards need to be changed because of the workforce crisis and we’ll consequently delete the standards that are in place.’ Our belief is that a rewording of that is the outcome that is required.

Senator HUMPHRIES—If we accept that the recruitment and supply of health practitioners is an issue that the registration processes need to take into account, how could we frame that so as to achieve what you are after without removing that power for the ministerial council to demand more responsiveness from the boards on that issue of workforce shortage?

Dr Hillis—The suggestion we made in our submission was that workforce supply is a continuous issue. Perhaps even the inclusions of ‘in exceptional circumstances in the public interest’ could be added in to give it a sense that a greater degree of public interest must be determined and that it needs to be exceptional circumstances. As I said, our reading of the words at the moment is that you could have this phrase active all the time. We believe that there may be some merit to have it in there, but it needs to be activated only in exceptional circumstances and, again, in the public interest.

Mr McAdam—While the number of people who are going to graduate from medical schools is increasing over the next several years through to 2012, it will be a number of years before they start to flow actively through to the workforce and we start to get the effect where that clause may not be as relevant as it will be, certainly for the first few years of the operation of this bill.

Senator HUMPHRIES—In your original submission, you raised some issues to do with the need for a specialist register. Has that issue been dealt with satisfactorily in bill B, as far as you are concerned, or is that still an outstanding problem?

Dr Hillis—It is still an outstanding issue. We believe that this needs to be taken a few steps further, firstly under protection of titles. In bill B, under the medical practitioner category, there is no speciality delineation of the individual practitioners within that group. Consequently, we believe ‘specialist surgeon’ and ‘surgeon’ should be protected titles. We are also concerned—

Senator HUMPHRIES—Can I ask about that? What is the purpose of that protection of title? It obviously goes beyond the status of the surgeon concerned. Is it about making sure that some other kind of surgeon cannot conduct the kind of work that that specialist surgeon conducts? Is that what it is about?

Dr Hillis—There are a number of things. 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 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.

Senator HUMPHRIES—Just on that point: a few years ago, a number of governments around Australia took the step of abolishing the title ‘QC’ for eminent barristers. They argued that it gave a status in the marketplace which was sort of conferred by ‘government’, which was more of an accolade or a sign of esteem by the profession as a whole. So the profession could confer the title of ‘Senior Counsel’, and it does in many states, but it was not up to the government to designate certain people as extra special barristers when they had no particular legal status by virtue of that. Is there any role the specialist surgeon that you are talking about here should be able to play for which legal protection would be needed to prevent other people from playing that role?

Dr Hillis—My belief is it is an issue of public safety. If you went to a person who portrayed themselves as a specialist surgeon, you would want to know that the person who is going to open you up operatively has had the right degree of training and has been determined to be at the right standards after they had finished that training program. By not protecting it, you then have it open that anyone can portray themselves as being appropriately qualified.

Senator HUMPHRIES—The consequence of specialist registration would be that it would be an offence for another surgeon to practise in that area of specialist surgery without having had that registration?

Dr Hillis—Yes.

Senator HUMPHRIES—Right. Sorry, please go on.

Dr Hillis—I was speaking to the issue of protection of titles. Some states of Australia already delineate the types of surgeons within the specialty register. We believe that should be considered, but certainly the title ‘specialist surgeon’ should be protected under the area we have talked about.

Senator HUMPHRIES—So you say that those states that do not have that specialist recognition for types of surgery are putting people at risk because the wrong sorts of surgeons might conduct that kind of work?

Dr Hillis—There is certainly confusion in the public’s mind as to who is able to do surgery and who is not able to do surgery or to know when they go to someone whether they have been appropriately qualified to do that type of work. Our belief is that, in the states where that specialty register currently exists, there are tighter controls over the standards in place. South Australia and Queensland do quite clearly state that they believe they have tighter controls.

In the registration area there does appear to be some confusion with the use of the words ‘specialist’ and ‘limited’. I particularly refer to proposed section 134 of the bill. I need to be clear that, certainly in the medical practitioners’ way of approaching this, one is given general medical registration first and, if one goes on and does more dedicated and specific training, they can become a specialist in that area. So you have general training first and specialist training second. That is the way most of the health professional training occurs, be it physiotherapy or whatever health profession group. In proposed section 134 they are now using the word ‘limited’. I need to highlight that just because you have undertaken more training does not mean that you are then limited to only that area. There are a number of surgeons, particularly in rural parts of Australia,

who do mix general practice with surgical practice, and appropriately so—they actually have the skills in all of them. They are not actually limited; they are specialised. There is quite a distinct difference in the use of those words.

One reason why I highlight that is that there is also 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.

I wanted to be clear about the use of those words. In the legislation there does appear to be at the moment some confusion between the use of the words ‘specialist registration’, which we would hold means general plus further training, and the use of the words ‘limited registration’, which is a limited component.

Senator HUMPHRIES—You made a comment in your opening remarks about mandatory reporting. Can you repeat what you said there?

Dr Hillis—Certainly. Mandatory reporting has been in Australia now for a number of years. Places like New South Wales have already put it in place. Our experience is that mandatory reporting is highly useful. However, there do need to be safety mechanisms to it. You do not want to stop a practitioner seeking support if they actually have problems. Our approach to this is that if another practitioner hears about someone’s ill health, or whatever it might be that might put people at risk, they should not be obligated report it, because it would make an individual less likely to seek help. In other words, if a doctor were to go to another doctor for care but knew that, as soon as they opened their mouth, they would have to be reported to the registration board rather than be treated, that would fundamentally change the patient-doctor relationship. 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.

Senator HUMPHRIES—You raise a general problem with mandatory reporting, where someone goes to see a professional with a problem for help and instead they are reported to the authorities. It can undermine people accessing specialists, care providers and service providers generally. But I suspect that the horse has bolted on all of that. Did you say that there is a medicolegal exemption which should be replicated for practitioners who seek help and to whom mandatory reporting might apply?

Mr McAdam—It seeks protection for those people who are in a treating relationship with a surgeon or any other medical practitioner. In terms of the medicolegal issue, if you become aware of a practitioner being outside the accepted standards but found that out through a

medicolegal case, you are not obliged to report them in a mandatory fashion. That is now exempted in the bill. That same exemption should apply for a therapeutic relationship between a treating doctor and a medical practitioner.

Senator HUMPHRIES—Earlier today some comments were made by representatives of podiatric surgeons suggesting that previous separate registration of their surgeons had been part of the earlier two versions of the consultation drafts of the bill but had been taken out in the third one. They implied that surgeons, or the College of Surgeons, might have knifed them—or ‘scalpeled’ them—on this issue. Is there an argument for not having separate registration for podiatric surgery?

Dr Hillis—The position of the College of Surgeons is there should not be. Podiatry in Australia is based on the United Kingdom model of chiropody, which is foot care. The model that has been taught traditionally in Australia in chiropody is the care of feet—an incredibly useful and required area—but it has been contained particularly to the soft tissues of the forefoot. That has, as I said, made an incredibly useful contribution to health services. In the United States there has been a different model and a different undergraduate program has grown up where they have been more aggressively trained in some surgical procedures. I understand there is a desire amongst some of the podiatrists to have that model introduced here. The College of Surgeons’ view is that at the moment the undergraduate training program that podiatrists go through, and certainly the postgraduate program that they have, do not provide the standards to do anything further than the forefoot treatment. I understand the podiatric surgeons would like to progress to formal operations on the foot and the ankle joint. Certainly the view of the College of Surgeons is that is not appropriate, given the training and the standards that they have at the moment.

Senator HUMPHRIES—So you would argue that if a person has a problem with their foot or their ankle joint they should see a surgeon rather than a podiatric surgeon.

Dr Hillis—They should see an orthopaedic surgeon. All the orthopaedic surgeons in Australia are trained in foot and ankle surgery. There is access to those surgeons through the public hospital system and the private hospital system.

CHAIR—Dr Hillis, podiatric surgeons are registered in most states of Australia to do paediatric surgery. So you want to have that removed from them, is that right?

Dr Hillis—Certainly it is the position of the Royal Australasian College of Surgeons that the formal surgical training that they are putting forward does not have the required standards based on their undergraduate program and their formal training program. That is the case that we have made throughout the entire discussion.

Senator HUMPHRIES—I have one other question I was going to ask. You talked about the lack of any framework for the ministerial council and the minister to consult with the colleges before they declare areas of need to trigger those provisions in the act. Of course it is the ministerial council as a whole that makes that decision. There would be other areas of professional practice that would argue that they also need to be consulted about arrangements for the declaration of areas of need.

You could, I suppose, build in a requirement to consult before taking such steps. I would imagine that it would be difficult to try and specify what is required. The trouble with putting that in legislation is that it begs the question: who are the required parties to consult with? If you try and list them in the legislation, you end up with a whole problem of omission. Is it practical to do that? You might say, 'Look, consult the colleges,' but other stakeholders will say that it is just not acceptable to only consult the colleges. How do we solve that problem?

Dr Hillis—You could use words like 'the appropriate professional body'. That may be useful in the drafting process because—

Senator HUMPHRIES—Then it becomes a matter of legal interpretation as to what is then the appropriate body. And if a party could establish that the council did not consult with them and they were an appropriate body then they could potentially overturn a decision that was made by the council on the basis of not having had consulted with them. I think that is the danger with specifying it in legislation like that. Sorry, I interrupted you.

Dr Hillis—I guess, on the fly, I am not able to give you exactly the right words to answer your question. This does not just relate to the medical area; there has obviously been an area of need declared for the nursing profession and others. It is our view that there are often reasons beyond just a shortage of people that need to be thought through in order to be able to recruit people, particularly to remote and rural areas. Often it is the infrastructure of a particular facility that is not adequate to the task and if that were addressed then they would be able to attract people to it. That has certainly been our experience in a number of difficult areas across Australia where recruitment has been a challenge. When we were asked to be involved, we were able to provide guidance as to—and this is about not just a shortage of people but also a shortage of infrastructure—the broader issues that need to be addressed. Often the health workforce shortage is really just a manifestation of a whole raft of other things going on. As to the wording, it may be that the ministerial council needs to have a designated subgroup of the accrediting body or the national board that could look at these issues.

Senator FURNER—I am just wondering whether you can go to some more detail in your submission on this notion of listing deregistered practitioners however not disclosing what the conduct related matter of the deregistration is.

Dr Hillis—This particular issue reflects that it is certainly important that the public is aware whether someone is registered or not. So that information needs to be made readily available. The dilemma is that often there is a specific subsection put on that can be incredibly publicly humiliating to the individual concerned. So what we are really after is just a top-level registered or not registered designation rather than the specifics being put in place.

Senator FURNER—And what would be the subsection you were referring to in your example?

Dr Hillis—The issues around personal conduct and those types of things are reflected and certainly people do feel as if they are being exposed to unnecessary humiliation for something that may be an event that occurred in the past.

Senator FURNER—And what do you suggest in terms of the removal of old decisions from the register? What sort of period of time are you suggesting there?

Dr Hillis—Certainly our view is that that should be left, in context, to the board who has done the investigation on that issue. It may be that a 12-month or a 36-month period would be more than ample. The board that is actually doing the investigation should have the capacity to remove those things promptly and not allow them to sit on the register for a period of time.

Senator FURNER—So they would be the decision maker based on the severity of the discipline, basically.

Dr Hillis—That would be appropriate.

Senator BOYCE—It has been raised a number of times that a national registration scheme should stop the sorts of situations that surrounded the work of Dr Jayant Patel. How would your view that these complaints should come off the register within 12 months or two years assist a national scheme of people who were not practising correctly?

Dr Hillis—I need to say that the Dr Patel case was an extraordinary circumstance.

Senator BOYCE—I realise that, and that is why it is the example that is most referred to.

Dr Hillis—Because for every Dr Patel that we read about in the media there are many other health practitioners who are duly reviewed by the appropriate practitioners board. There are a number of issues that do get investigated by the medical boards and the other health practitioner boards. My previous suggestion to Senator Furner was that it should be up to the discretion of those boards as to the amount of time that is left on there. The view of the professionals—

Senator BOYCE—But that would not be a public document anyway. So a private and confidential note would not remain indefinitely either, is that what you are suggesting?

Dr Hillis—Yes, that is correct. On the issue of Dr Patel, if a person is deregistered and deregistered for substantial events then perhaps that should be, again at the discretion of the investigating body, be made permanent. I think there needs to be a spectrum of response to this, recognising that there is an ongoing issue of people wanting to rehabilitate themselves to actually get back into proper health professional practice and that having them on the record for a long period of time really does substantially interfere with that. On the other side of the coin, the public obviously needs to be appropriately informed.

Senator BOYCE—Yes, there is also the ongoing issue of public interest and the fact that it would appear that in some circumstances health professionals have moved from state to state as a way to avoid having to cease practice or change their practice.

Dr Hillis—Yes, that is absolute fact.

Senator BOYCE—So how would you propose that this be enforced if your misdemeanours, for want of a better word, are only to be listed confidentially to a small group of people and then only available for 12 months?

Dr Hillis—There are two issues around this. On the issue of the degree of notification on the website or wherever it might be, the college's view is certainly that it needs to be stated that there is a registration issue. We are not backing away from keeping the public well informed.

Senator BOYCE—So that would be publicly available?

Dr Hillis—Yes. That needs to be there and it needs to be clearly stated. Our view though is that the ongoing presence of that, beyond the time when people are able to get back into practice fully, needs to be carefully looked at—and removed.

CHAIR—What happens now, Dr Hillis?

Dr Hillis—It varies across the jurisdictions. That is why we are stating the point. At the moment it is variable. Many of the jurisdictions actually do state that 'this person is only registered to practice this type of work' or that 'they are restricted because of these activities'. What the college is trying to do is to make sure that, as it moves forward, it is only kept there clearly for a limited period of time.

Senator BOYCE—Just going back to your comments around protecting the titles of a specialist or surgeon et cetera, you say here, 'There are overlapping scopes of practice, that there are many of them and that involved professions should communicate and reach agreement.' Could you perhaps give me an example of how that might work? What are you actually suggesting should happen there?

Dr Hillis—There is no doubt that, as we move forward, the various professional groups will want to be involved in other areas of health service delivery and this is to be encouraged. Things that were revolutionary 20 years ago become standard practice into the future. I would particularly look at the nurse practitioner model, which is to be thoroughly endorsed, as a way of actually delivering health services in Australia. However, there are a number of activities that the nurse practitioner role could get into that could be at conflict with other health service providers. Our belief is that that needs to be talked about.

Senator BOYCE—As a conflict or an overlap?

Dr Hillis—It needs to be discussed between the various national boards, to say, 'We're moving forward with this type of practitioner role; are there are other concerns?' It also raises the issue of podiatry, which has already been raised by Senator Humphries. The podiatric surgery issue will, again, need to be addressed into the future, I am sure. Our belief is that it should be discussed between the boards responsible for podiatry and the boards responsible for medical practitioners in a way that can be clearly understood before it is actually approved by the ministerial council. If you look at the work undertaken by physiotherapists and chiropractors, you will see the same issues are germane. I am not trying to put forward here a medical defence; I am stating that there is a lot of overlap between the various professions. Technology continues to change and, as things evolve over five or 10 years, one of the benefits of this should be that there is discussion and recommendations are put forward on an issue, preferably by consensus, to the ministerial council.

Senator BOYCE—You have said, ‘It should be mandated that the involved professions communicate and reach agreement.’

Mr McAdam—I suppose the concern is that scopes of practice could increase in one area of medical practice and that another area of practice which would be impacted by that would remain totally in the dark until it, effectively, started occurring because they had not been appropriately consulted. Medical practitioners, for example, may have a concern about podiatry creeping into podiatric surgery and ankle surgery and would want to know about the fact that that was going to be an endorsed scope of practice for podiatrists in the future. They may have a point of view that they would wish to put to the ministerial council about the appropriateness, the protection of standards and patient safety, as far as a particular group of practitioners undertaking that sort of work is concerned. It is about information flow and about giving the parties an opportunity to consult appropriately and to be aware of increased scopes by other areas under the proposed bill.

Senator BOYCE—Nevertheless, if NRAS is operating correctly, any of this expansion would be by properly registered people undertaking properly accredited training, would it not?

Mr McAdam—That may be the case, but I guess the argument that we would put forward is that our college is the guardian of standards, as far as surgical practice is concerned, and that if another group of medical practitioners wishes to extend its scope of practice into an area where we are providing the approved standard of training, we believe the medical board ought to know about that and that our college and other affected practitioners would want to have a say in that and inform the ministerial council’s decision-making process.

Senator BOYCE—What would your view be if people were to suggest that this was in some way a matter of just simply protecting your territory?

Mr McAdam—We would argue that it is a matter of patient safety.

CHAIR—Do you have statistics, Mr McAdam, in terms of the process? We do not want this to degenerate to just one issue, but it has come up several times today. My understanding is that the statistics have been kept for many years on podiatric surgery, as opposed to orthopaedic surgery, on lower limbs, ankles and feet. Do you have something on record that we could see that indicates your concerns about podiatric surgery?

Dr Hillis—No—not on record today.

CHAIR—Can we get it, if the college has these views?

Dr Hillis—I can certainly go back and investigate.

CHAIR—That would be very useful.

Dr Hillis—I would just like to speak to the more general issue. To be honest, obviously podiatric surgery was the issue of some discussion this morning—

Senator BOYCE—It is not just there. As you point out, there is quite a lot of current overlap and there is potential for a lot of future overlap.

Dr Hillis—Correct. To echo what James just indicated, the standards that have already been determined in certain areas, if they are felt to be appropriate by the broader community, should preferably be maintained. That is where the discussion needs to happen. I take your point about the issue about agreement, but there certainly needs to be discussion and it preferably needs to be worked through rather than just presented as a fait accompli to the ministerial council. You need to be conscious that in an earlier version of this there was no consultation between the various national boards built in at all.

Senator BOYCE—Should there be a body that does that? I hate to suggest it, but is there room for another body that does actually communicate to the boards the moves in each of the boards?

Dr Hillis—That is why we want it built in. The communication has to happen before an outcome is presented to the ministerial council. We certainly would not want another body imposed on it yet again, because of all the bureaucratic reasons that would create, but I think ensuring that there is proper discussion between the various groups is appropriate.

Senator BOYCE—Thank you.

CHAIR—Thank you very much.

[3.42 pm]

MARTIN, Mr Grant, Director, Professional Services, Pharmaceutical Society of Australia

SORIMACHI, Dr Kay, Director, Policy and Regulatory Affairs, Pharmaceutical Society of Australia

CHAIR—Good afternoon and welcome back. You are very experienced now and you will have all the information on parliamentary privilege and the protection of witnesses. We have your submission. I invite both of you, or either of you, to make an opening statement and then we will go to questions. I just want to check with you about the date of your submission. Was it before or after bill B was made public?

Mr Martin—Before.

CHAIR—So some things may well have changed. We will see how it goes. Mr Martin, I take it you will lead off. You seemed to be getting ready, so I thought you were ready to go.

Mr Martin—Thank you for the opportunity to present to the committee. The Pharmaceutical Society is a body that represents approximately 75 per cent of pharmacists in Australia. We draw our membership from all walks of pharmacy: community, hospital, government—across the whole range of the pharmacy spectrum. We have been actively involved in the process of reviewing the accreditation scheme for health professionals since 2006. I believe we have made a number of submissions on the topic. We have a range of recommendations or issues before you today in the submission, but we do acknowledge that the bill B exposure draft has answered some of those questions for us and has made clear other areas. My colleague, Kay, will speak to some of those newer areas. She will comment on those in particular. I will briefly go through the initial recommendations prior to bill B being delivered to the profession for comment.

There is a concern for PSA about the inclusion of mandatory criminal history checks. While we support that idea and concept fully, we do have some concerns about the time lines. We believe that, while they should be in place, there should be acknowledgement that they do need to be done in a timely fashion so as not to interfere with or reduce someone's opportunity to work as a pharmacist.

Another area of concern for the profession is with regard to registration fees. While this is possibly a minor issue, there is a lot of concern about how high the fees will be and where they will go, and we are looking for some indication if possible from the group behind the scheme as to where that is leading.

Another area of concern for PSA is our role in the development and implementation of professional practice standards, competency standards and the code of professional conduct. PSA have been actively involved in these projects for many, many years and we would like to be involved in them in the future, given our experience and expertise. The wording of the legislation as it is now does not make it clear that we will have that opportunity, and we are quite keen to work with the new national pharmacy board to maintain that role.

Another area that we think has dropped off the radar to some degree is the ownership provisions for pharmacies. While the scheme does not refer to them directly, they will perhaps be influenced by the national registration scheme. We are keen for those provisions to be taken up by the new, state based boards within the board and we are looking to see what will happen in that regard. We would also like to acknowledge that the current experience in the state based pharmacy boards is something that should not be lost. To some extent that has been addressed by some of the newer provisions of bill B. We see that there is expertise and experience and delivery options for the new board under the existing scheme and we are quite keen to see that those provisions are maintained. My voice is going to a whisper entirely, so I might pass over to Kay.

Dr Sorimachi—I will perhaps start with clarification in relation to our recommendation 5(d). We do acknowledge that there is a statement in the intergovernmental agreement of March 2008 in which there is reference to the states and territories remaining responsible for those provisions. However, 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.

My colleague referred to PSA's role in developing professional guidelines and a code of professional conduct. That is an activity that has been a core part of PSA's being for perhaps the last hundred years or so, during which we have been involved in those benchmarking activities. It is somewhat unclear, even with the release of the exposure draft of bill B, whether a body other than what is referred to as the 'external accrediting body' can have a legitimate role in continuing to develop these kinds of documents and have them applied by pharmacists. We also refer to the importance of these documents as they are embedded in legislation, such as those which impact on the approval for pharmacists to dispense pharmaceutical benefits, and we would therefore suggest that our role as a body other than an external accrediting body can continue under the new national law.

We support the provision for mandatory reporting. We believe it is an important initiative to enhance patient safety and patient care. However, we do have some concerns about the ability of practitioners who recognise that they may be in need of support and advice to actually seek such advice if the provisions are such that that would immediately mean reporting of those practitioners. That would discourage them from seeking early advice. Certainly, if practitioners who are involved in providing treatment or support were obligated to report back to the national entity then, again, their role might be somewhat confused and compromised.

The Pharmaceutical Society of Australia, through its Victorian branch, actually has a pharmacist support service. It operates only in the state of Victoria at present. It is a 24-hour telephone support service. It is a confidential service. Pharmacists who may have stress related issues or are experiencing trauma can seek early advice from a peer. This may complement their approach then to other more formalised treatments through medical practitioners or other specialists. We believe that this kind of service and this kind of mechanism to assist practitioners must be able to continue under the national legislation.

We do have some concerns, which we will outline in our follow-up submission to this committee, in relation to the definition contained in bill B for 'accreditation standards'. There are numerous references to the term 'accreditation standards'. Our belief is that it is somewhat confused with the actual definition of competency standards and, therefore, this does again impact on the role of the externally accrediting body as well as the role we might fulfil primarily because we are the custodians of competency standards for the profession.

Another issue relates to the composition of the national pharmacy board. Because of what we mentioned initially about 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 smaller participating jurisdictions would be allowed only a combined nomination is not adequate for the pharmacy profession.

An issue which has arisen with the release of bill B relates to the continuing professional development requirements of practitioners. This is an important aspect of continuing practice by pharmacists and other health practitioners; however, we note that there will not be any continuing professional development requirements for non-practising health practitioners. This we believe requires further consideration because currently under state and territory law there is in some cases a non-practising category. A pharmacist who has a pecuniary interest in a community pharmacy may be classified as non-practising and thereby under the new law those practitioners would not require CPD. We do not believe that is appropriate. We believe that any non-practising pharmacist who has a pecuniary interest in a pharmacy must meet all CPD requirements as per practising pharmacists.

Senator BOYCE—Why do you think that non-practising pharmacists should have to meet CPD requirements?

Dr Sorimachi—We believe that the owner of a pharmacy must be responsible for the practice within the pharmacy. Whether or not you are actually there dispensing and providing services, you are responsible for the competence of the staff.

Senator BOYCE—So you can oversee the level of competence of your pharmacy staff?

Dr Sorimachi—Yes.

Senator HUMPHRIES—I am sorry but I have to go somewhere so I will put some questions on notice for you. You mentioned state representation on pharmacy boards. We have had other evidence from people today who have argued that the board should consist of the best people in a particular occupation group, not necessarily the most representative in terms of covering each state and territory. You have argued the opposite. Can you convince us as to why your model of each state getting a person is better than a model where you choose the best people to go on the board? Are there special reasons in pharmacy which mean that you need this kind of model but you might not need it in other occupational groups?

Dr Sorimachi—The best people may certainly have the appropriate oversight in terms of pharmacy practice; however, there may be state or territory specific issues that a pharmacist who does not practise in the smaller jurisdictions may not be aware of.

Senator HUMPHRIES—Like what for example?

Dr Sorimachi—In terms of ownership there may be some location specific issues that arise.

Senator HUMPHRIES—But you said that ownership should stay with the state and territory governments didn't you?

Dr Sorimachi—Yes.

Senator HUMPHRIES—Presumably, ownership issues would not arise. They would be matters for the state and territory governments to deal with. What sort of issues would the national pharmacy board need to know about in Tasmania or the Northern Territory that would mean they would have to have someone from those jurisdictions on the board?

Mr Martin—There is possibly Poison Act specific information. Each state has its own particular set of rules for medications in all the various forms. Having someone who is aware of the nuances of that would be important for an overall consideration of issues. It is possibly not a dramatic issue but it can mean that there is an information gap or lag in the national board being aware of the state specific issues.

Senator HUMPHRIES—The idea is to get a national standard so that people do not have to worry about training in one place and then not being able to practise in another—the sort of nonsense about not being able to cross borders with your qualifications. If you have national standards, does it matter if different jurisdictions have different requirements? It is the obligation surely of the pharmacist to know what the requirements of each jurisdiction are as far as the Poisons Act is concerned before they practise in them. There is an argument for that being standardised as well in due course but that is another debate. Is it really important to have people who understand the provisions of the Poisons Act on the national board? Could you not cover that with advice to the board?

Mr Martin—I could hedge a bet and say that you probably could in the longer term. In the short term though, in the initial phases of the new system, maybe that is the time to have state based experience and you could move to the model you are suggesting over time. In the early stages, given that there are sometimes big differences between the states, that particular knowledge may be useful to the board in that instance.

Senator HUMPHRIES—Okay. I will leave it there thanks.

Senator BOYCE—I just wanted to go back over what you were saying earlier about your training and educative role. Interacting with boards, is that what you were suggesting? Were you suggesting some sort of subcontracting job for bodies like yours?

Dr Sorimachi—We were trying to reiterate that one of our core functions is the setting of professional standards and we also develop professional guidelines. We have a code of professional conduct. All of these documents are currently adopted by the state boards which, if they have a disciplinary matter, for example, will refer back to the PSA standards as the appropriate benchmark standards of practice. The scope of that role is not evident as being able to be exercised by a body other than an external accrediting body. There seems to be some

confusion about the exact role of the external accrediting body. It does suggest that the main function of the external accrediting body will be in accrediting, for example, programs of study and we believe that is appropriate. That already happens within the pharmacy sector through the Australian Pharmacy Council. We want to make sure that we are not excluded from carrying on our normal core duties for the profession in providing those standards, codes, guidelines and so on by the lack of mention, if you like, of any other body being able to undertake that role.

Senator BOYCE—As I understand it, you are actually providing education or training not about being a pharmacist—

Dr Sorimachi—We do do that.

Senator BOYCE—but about how to run a pharmacy and manage pharmaceuticals. No?

Mr Martin—Our primary concern is the pharmacist and the professional services. The management of a pharmacy is more of a Pharmacy Guild perspective. Our role is to educate and provide support on the clinical side of pharmacy. A professional practice standard is a good example.

Senator BOYCE—I am sorry, Mr Martin, could you just repeat what you said.

Mr Martin—PSA's professional practice standards, for example, describe how a pharmacist would deliver a professional service like dispensing, like giving health information, like a diabetes management service. That is how the pharmacist acts with the patient on a clinical basis. It does not really discuss or cover the commercial side of that issue, so it is a slightly different focus and it has more of a clinical basis.

Senator BOYCE—But PSA have no involvement in the development of a bachelor of pharmacy?

Dr Sorimachi—No, although we do have representatives on a committee which is involved in the accrediting function.

Senator BOYCE—I think I understand that now. You mentioned a peer support program that was operating in Victoria. Could you tell me a little bit more about that.

Dr Sorimachi—It is a service which has been running since 1995. The service is provided by volunteer pharmacists. The service is currently only provided in Victoria, but there are 17 or 18 volunteer pharmacists who undergo training through psychologists and Lifeline—that sort of equivalent training. The service is a telephone based service—a 24-hour confidential service—and it caters for pharmacists who may have stress related issues. The originating concern was primarily around trauma incidents such as pharmacy hold-ups. It is fair to say that now many pharmacies have protocols in place to deal with that kind of traumatic incident, so the types of calls perhaps fall more into the stress category—so it might be workload issues, dispensing errors, workplace conditions and that kind of thing. The service also caters for international registrants who might be transitioning to practising in Australia, where they have concerns.

Senator BOYCE—That might even be an advice line for people like that?

Dr Sorimachi—Yes. It is a peer support. Where it is a health related issue, then the volunteers are trained to provide appropriate referral. Often pharmacists, if they experience that kind of incident, are not sure where to go for more formalised help, so it provides a direction to those pharmacists. I believe in 2007 the Australian Medical Association in Victoria wanted knowledge about the service, and in fact we have assisted AMA Victoria in setting up a similar service. As I said, it is only operational in Victoria, but, with the national registration, we believe that if we are able to canvass options to make it a national service we would like to do that. Obviously the referral rate would go up in proportion with the number of registrants, and perhaps outside of Victoria—Victoria is a fairly small state with a contained professional sphere, if you like—in the larger states, where the formalised services are perhaps not as easy to reach, we believe there is great benefit in that kind of service.

Senator BOYCE—And the poison schedules are different. So it would be quite possible for a volunteer pharmacist involved in this program to be made aware of, for instance—as you said—an error in dispensing that could have been a subject of a complaint.

Dr Sorimachi—Yes.

Senator BOYCE—And perhaps something like a drug addiction.

Dr Sorimachi—Yes. It is promoted of course as an anonymous service, but where there are ongoing interactions between the volunteer and the pharmacist then sometimes the pharmacist may prefer to let their identity be revealed. That has happened and I believe that in some instances the volunteer may even accompany the person to a Pharmacy Board hearing if that is their preference.

Senator BOYCE—So some of the people who have come for support have subsequently been required to justify what they are—

Dr Sorimachi—The way that the pharmacist approaches the support service may be after they have been made aware that they are under investigation. It is not always necessarily the very first step. So they may already be under investigation.

Senator BOYCE—And they may have decided that, because of that, they have to do something about the problem that has caused the investigation?

Dr Sorimachi—Yes, and it may even be after they have already had a consultation with a medical practitioner if that is the appropriate way to go. I think the benefit that the pharmacists perceive is being able to talk to another pharmacist about pharmacy practice issues.

Senator BOYCE—So how would you suggest that the bill might be amended to weigh up the public interest of mandatory reporting on one side and this self-help exercise on the other side?

Dr Sorimachi—There is probably no simple answer. We understand that bill B will have levels of tolerance, if you like, of the different categories of misdemeanours or health issues. Obviously where there is immediate risk to the public or if there is likely to be ongoing risk then that is probably something that needs to have some sort of judgement made. We would probably have to talk further with the service, which is provided through the Victorian branch, about how

they feel they can contribute not only in the reporting aspects but also in supporting pharmacists who approach the service.

Senator BOYCE—It sounds like a very interesting and useful program.

Mr Martin—I think the risk is that if the legislation is too black and white then it just drives those people further underground and they will not actively seek support. That is probably the differentiation—they are actually looking for help. That is probably something that we should be encouraging rather than sort of separating them again.

Senator BOYCE—There is a public interest assessor who has developed in bill B. Can you give me the view of the Pharmaceutical Society of Australia on this proposal?

Dr Sorimachi—Yes, we are opposed to it. It has come as somewhat of a surprise. I do not believe there has been any previous mention of it until it was put in the exposure draft to bill B. I guess one of our main concerns is about timely decision making. When any health practitioner is subject to a complaint, one of the important things is timely resolution. We believe that an additional step, although the proposal is that it will run in parallel with the national board's considerations, is another layer or another process that needs to take place. We feel that that may compromise the timely decision-making aspect. 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. In some ways we feel that this in essence duplicates what the board should be doing in terms of assessing and managing complaints.

I guess one of the issues in the proposal is that if the public interest assessor deems that the issue is more serious in terms of the outcome than what the national health professional board has determined then the public interest assessor's decision prevails. We think that is entirely inappropriate. On the composition of the board, there are community members on the national practitioners boards and we feel that that should give some balance. We understand that consumers are concerned about transparency and accountability. But we think that having that—and I think the proposed ratio is no more than two thirds of the practitioner members on the board—provides a good balance. We would support rigorous decision-making processes of the board rather than having a separate body overseeing what the board is doing and then potentially overturning their decisions.

Senator BOYCE—Thank you.

Senator WILLIAMS—You are adamant that assessment of the standards must remain with you.

Dr Sorimachi—Yes.

Senator WILLIAMS—You have made that quite clear. Does it concern you that this may change with the establishment of an NRAS?

Dr Sorimachi—Yes.

Senator WILLIAMS—Obviously it does. Have you had any indication of change in that respect?

Dr Sorimachi—We have not seen enough detail to suggest that it will change, but the fact that there is still the potential for change does concern us, because it is our primary role.

Mr Martin—We felt it was important to highlight it here and now, before the process is set in place. It may simply be that we work closely with the new national board at a later point to do what we are doing now and continue to provide that detail for the profession. But it is vital that we have it on the table straightaway, before the board comes into being.

Senator BOYCE—One issue that was raised by the Pharmacy Guild was the fact that there have not been any business plans or costings done on how the national registration and accreditation scheme will run, whether the registration fees will be sufficient and what will happen in terms of how you go about funding accreditation. The concerns that I imagine you share are that this could leave the current registration of premises and the like as an unviable proposition in the states. Have you done any work on this, or can you give me any sense of what percentage of fees would come from registration of pharmacists and what percentage would come from registration of pharmacies, for instance, within the states?

Mr Martin—I am not really familiar with the registration fees for premises. Obviously registration fees are more of a concern for the pharmacists.

Senator BOYCE—But I understood from what we were told by the Pharmacy Guild that their concern was that the fees from all of these go into the one pot that keeps the state boards viable. Their concern is that, once some of these fees come out, what is left behind may be unviable or lead to big jumps in cost.

Mr Martin—A concern of our members as individuals is that the rates will have to go up to cover the new infrastructure and the new costs. Having premises registration linked to that as well just puts more of a burden on what has to be paid. As to what the proportion is now, we are not really aware.

Dr Sorimachi—The pharmacy boards would have all of the figures in terms of both the actual dollar amounts and the proportions of pharmacists versus pharmacy registration fees. But we do not have access to that information.

Senator BOYCE—It would appear that the pharmacists are the only group that have this dual stream.

Mr Martin—Yes. With the pharmacy-only ownership of pharmacies, that is part of the reason.

Senator BOYCE—Thank you.

CHAIR—Is there anything you would like to add that we have not asked you?

Dr Sorimachi—Not today, but we will be following up with a written submission to the committee.

CHAIR—Thank you very much.

Proceedings suspended from 4.14pm to 4.28 pm

COWIE, Dr Peter, Delegate, Australasian Conference of Chiropractic Registration Boards

CREAN, Dr (Chiro) Stephen Ross, Chairman of Working Party, Australasian Conference of Chiropractic Registration Boards

SHOBBROOK, Mr Michael Andrew, Representative, Australasian Conference of Chiropractic Registration Boards

CHAIR—Welcome. There is absolutely no reason that I need to know this, but I am curious: could I find out where each of you are from?

Dr Crean—I am in Hobart.

Mr Shobbrook—I am in Canberra.

Dr Cowie—I am in Wesley, Sydney.

CHAIR—That gives me an idea of where you are. Would any of you like to make an opening statement? Then we will go to questions. Who is taking the lead?

Dr Crean—Good afternoon. I hope the day has gone in a constructive fashion. Thank you very much for taking the time to hear our submission. The chiropractors registration boards, with respect to their registration and accreditation system and in particular bill B, have got a number of major concerns. The first priority is the proposed restriction on spinal manipulation. Historically in Australia, six out of eight of the registration boards have had a restriction of practice on spinal manipulation for the full spine. That means that only those people who are listed—that is, chiropractors, osteopaths, physiotherapists and medical practitioners—have the legislative ability to practise spinal manipulation. The proposal in bill B restricts that practice of spinal manipulation to the neck only. That means that any person in the world could hold themselves out to perform spinal manipulation of areas of the mid-back or low back, there is no legislative control and no requirement for them to have undertaken any form of training and there is no recourse to protect anyone who might be injured. We have a proposal that says that the spinal manipulation restriction of practice should be to the full spine. If I may ask a question: there was a supplementary submission and I wonder whether that has, per chance, arrived on the desk?

CHAIR—I believe it has, dated 9 July 2009.

Dr Crean—Yes, indeed.

CHAIR—Yes, we have it, Dr Crean.

Dr Crean—Thank you. The second key point is around the issue of competency. In two of the new current acts, in the Northern Territory and the ACT, there is an issue surrounding the competency to practise spinal manipulation. The chiropractors registration boards believe that if any of the listed practitioners—chiropractors, osteopaths, physiotherapists and medical practitioners—are going to perform spinal manipulation, they need to be trained and be competent to do so. Bill B, as it is proposed, is silent on this matter. We believe that there needs to be a potential to ensure that those who do practise spinal manipulation are capable of assessing the risks, modifying treatment and ensuring that we have healthy outcomes. This is quite significant in that, for chiropractors and osteopaths, this is a major core component of our course, as part of our five-year undergraduate programs, but there is no requirement within the undergraduate programs for physiotherapists and medical practitioners to be taught spinal manipulation. There is, however, a variety or a diversity of postgraduate programs for physiotherapists and medical practitioners, and we have the legislative opportunity to ensure that the higher standards are maintained. We have recommendations on that.

The third point is that historically chiropractors at both an undergraduate level at university programs and in practice for the last two, three or four decades have been able to assess and treat around people's jaws, their ears, the sides of their heads and the muscles inside their mouths and on the outside of their mouths to help correct TMJ, malocclusion and various forms of muscle conditions. The new legislation has a dental restriction. If we look at the dental restriction proposed we see that it means that it will remove the potential for chiropractors around the whole country to perform the procedures that we have been performing for the past 20 or 30 years. So we have a recommendation to make on that.

There are two other issues that are important. The draft legislation has included a structure for a public interest assessor. This is proposed to be a person who would work with the national chiropractors boards and all of the other health professions boards in a role to look at complaints and the way complaints are managed. This has been pushed by consumer groups to add another layer of transparency. The chiropractors registration boards, in fact, would suggest that the role of the public interest assessor will be well done by the three current consumer representatives on each national board and that there already exists a proposal within the new structure for an independent assessor at every state and territory level to liaise at that level regarding complaints.

Around the country at the moment, the independent assessor role is well performed by the health complaints commissioners. We see that the role of the public interest assessor adds another cost and another layer of administrative burden to a system that really does not need that to be there, and we see that it is adequately taken care of by the structure of the national board and the independent assessor at a state level. Perhaps in some ways the most important issue that is generic for all of the stakeholders involved in the national registration and accreditation legislation is that there has been—certainly within our boards—identified no less than 100 mild drafting errors and probably 20 to 30 significant interpretational errors within bill B. The matters that we see as very significant we have just outlined, but there seems to be no provision for any stakeholders to review the second draft of bill B. We think that going from a first draft to no ability to respond to the 100 to 120 errors that we have already identified seems to be an oversight. We think that somehow there needs to be an ability to redress that.

Those are our opening comments. We would be pleased for your questions.

CHAIR—Thank you.

Senator BOYCE—To follow up on that point you mentioned about the 120 errors, do you intend to list those and present them to Dr Morauta's committee?

Dr Crean—The state chiropractic boards, individually and jointly as the chiropractors registration boards, are already underway and probably reasonably well on the way toward presenting those. We have a deadline for that on Friday. The matters that we brought up regarding spinal manipulation, competency and that are also going to be part of that submission, as they have been to you.

Senator BOYCE—Could you provide to us a copy of that list once it is developed? That would be very useful. Earlier today, I made the mistake of thinking that the supplementary submission you had sent in was the one from the Chiropractors Association of Australia; we have certainly canvassed with them the issues that you have raised regarding spinal manipulation and the changes around dental manipulation. I would like to follow up with a few areas there. I asked the Chiropractors Association if they were able to give us any facts or figures to support their contention that spinal manipulation by people who were not chiropractors or osteopaths was dangerous. Are you able to assist us there at all?

Dr Crean—Dr Peter Cowie would be able to help respond to that.

Dr Cowie—Those statistics exist and they will be provided in our submission. The problem with the statistics is that in some cases those statistics of injuries are thin on the ground because for the last 30 years nobody has been able to perform the procedures that chiropractors perform unless they have been a registered chiropractor. In those jurisdictions—six of eight—where spinal manipulation has been restricted wholesale, nobody has been allowed to do it—

Senator BOYCE—I think Victoria and Western Australia are the two states where it is not restricted.

Dr Cowie—That is correct.

Senator BOYCE—Any figures out of those two states that differed significantly from the others would of course be quite useful in supporting your contention here. Have you got any anecdotal information that you can give me.

Dr Cowie—Not anecdotal. In those jurisdictions where the restriction does not exist—Victoria and Western Australia—the people who have been injured have nobody to complain to. If a person goes to their football club and their masseur does something to their spine and injures them, there is nobody for them to complain to. So, we believe that those complaints are hidden in those jurisdictions as they are also hidden in the jurisdictions where the restriction exists because for the last 30 years nobody has been able to do it. In those jurisdictions where the restriction exists, removing the restriction would be like saying, 'Well, we have not had many people killed by handguns in New South Wales so let's lift the restriction on handguns.' That restriction has been in place for such a long time that the public and the people likely to provide these services are very well aware of that. In a recent examination of over 300 complaints in New South Wales over the last 30 years, in the first 10 years there were numerous complaints of

injuries and people complaining to the registration board about unregistered practitioners. In the last 20 years there were very, very few.

Senator BOYCE—Would you see that as supporting your contention that having restriction on who can perform spinal manipulation has been helpful?

Dr Cowie—That is correct. If a person in Victoria or Western Australia is injured by their football trainer or a Chinese masseur or whoever is likely to perform these procedures and they complain to the Chiropractors Registration Board, it is not within their ambit to pursue that because it is not an offence, and there is nowhere in the Public Health Act—they could go to Fair Trading I suppose. But in general there is nowhere for those people to complain to, so those figures are likely to disappear.

Senator BOYCE—In terms of the fact that cervical manipulation is the only one that has been restricted, have you had any explanation at all as to why that change has been made.

Dr Cowie—I think that generally speaking the restriction on cervical manipulation is the most obvious one because if anyone is going to get damaged by manipulation it is the cervical one that causes the greatest concern. I was speaking to a chiropractic expert witness a couple of weeks ago who has looked at over 300 cases of chiropractors with injuries over the last 30 years. He said that of those 300 probably about 120 of those are lumbar and mid-thoracic area. So about 30 per cent of all injuries from people who are trained occur in lumbar spine as opposed to cervical spine.

Senator BOYCE—I am not quite following that point.

Dr Cowie—We believe that of all injuries probably 30 to 45 per cent of injuries from manipulation, in practised hands, occur within lumbar spine and mid-thoracic spine as opposed to probably 50 to 60 per cent cervical spine.

Dr Crean—If I may answer the question you are asking, specifically: why there is the proposed restriction to cervical spine—

Senator BOYCE—Have you had any explanation as to why that has been done.

Dr Crean—When the national forum came to Hobart recently, I had a chance to talk with Chris Robertson, who is on the national registration and accreditation team; he is one of the draftsmen. I would suggest that the ‘cervical spine restriction only’ to date is a combination of fact—the area of greatest harm; the area where there is published injury, stroke, Horner’s syndrome and death—and politics. There was a political compromise to achieve a restriction, where one particular state minister was quite opposed to it, based on the fact that they had not previously had a restriction and that state argued that there should not be a need. So there was some science and, I would suggest, some politics in that.

Senator BOYCE—So we are talking about Victoria or Western Australia, I presume.

Dr Crean—We are talking about Victoria.

Senator BOYCE—Thanks for that. A point that was raised earlier was that both chiropractors and osteopaths have significant amounts of training—I think over 5,000 hours was mentioned—in spinal manipulation, but medical practitioners, who are also able under this proposed bill B to do all spinal manipulation, have very little mandated spinal manipulation training. What is your view on medical practitioners being allowed to practise all forms of spinal manipulation?

Dr Crean—I think the chiropractors registration boards take the view that we are there to protect the public and therefore it is arguable that anybody who has the right and responsibility to perform this practice need to be qualified. The standard for qualification for chiropractors is completing an accredited course at one of the three universities in Australia and there are methods for overseas people. However, there are no set standards for the other professions. So it would certainly seem responsible—considering that we understand that there is risk and specific knowledge required—that these other two professions need to have some way of ensuring that they are working in a competent and reasonable fashion for their patients.

One argument has been that we need to perhaps have accredited courses. The World Health Organisation, for example, have set a very clear policy on guidelines for spinal manipulation for non-chiropractors and osteopaths. In conjunction with the New Zealand royal commission, they have recommended a 12-month graduate course would be consistent to achieve the level of knowledge and skill required to perform spinal manipulation in a rational and competent fashion. So there is a baseline of recommendation.

Senator BOYCE—Going back to your original submission, I note that you recommend that there not be a definition of spinal manipulation in the legislation. Why is that?

Dr Crean—Spinal manipulation means different things to different people, and the experience of the registration boards has been that, the more we try to define an act, the more it becomes a very significant legal test to determine what it is or what it is not, and drawing the line very clearly in the sand sometimes made it very hard to manage dealing with complaints. So the first position that we took in some states—and Tasmania is one—is that spinal manipulation is not actually defined; it is defined as purely the restricted practice is spinal manipulation and should there arise an occasion for a complaint, it is determined by the complaints committee of the board as to whether or not they were performing that act.

Senator BOYCE—So that is where you would see an accredited course covering the problem of—

Dr Crean—The accreditation bodies of all of the professions do not at the moment accredit courses in spinal manipulation; they accredit a medical undergraduate program—a chiropractic undergraduate program. So they do not do that at the moment, and there would be a lot of work to try and create that. However, each of the national registration boards has the ability to liaise with the other national registration boards about the issue of what is a sufficient course to establish competency in spinal manipulation. So it is a much more workable set of words.

Senator BOYCE—I also want to talk about the fact that osteopaths and particularly chiropractors would no longer be able to perform mouth and jaw manipulation under the current bill B. What discussion or correspondence have you had on that topic with Dr Morauta's committee and the forum?

Mr Shobbrook—It is part of the submission that we are putting in to meet the coming deadline. We were not aware of it in the drafting stages leading up to the bill. Until we saw the draft, we did not know this would present a problem. I do not think it is as contentious an issue as other issues; it looks to me that it may be just an oversight in the drafting of the dental part of the restrictions. It has been part of the scope of chiropractic practice for a number of decades and well before chiropractors became university trained. So we would like some provision or exemption put into the next draft to make sure that chiropractors and osteopaths are able to practice very competently and well, as they have been doing in the decades leading up to this legislation.

Dr Cowie—If I could add to that. Currently, in six of the eight jurisdictions, the definition of restriction on dental practice would permit chiropractors to continue to work with temporal and mandibula joints and to undertake oral cranial work. It is only two of those jurisdictions that would restrict chiropractors in being able to do that. It is possibly just an inadvertent oversight that they have adopted the definition that restricts chiropractic rather than one that does not.

Senator BOYCE—One hopes that, if the intended outcome is a nationally consistent scheme, you are right. I am happy to let others ask questions.

CHAIR—Senator Abetz, do you want to ask any questions?

Senator ABETZ—Thank you, Chair, but I am very mindful of the fact that I am only a participating senator and have not been actively involved. So, if other senators have questions, I would be happy to ask a few at the end.

CHAIR—I tend to go to the opposition senators first. That is why I asked you, senator. I will go to Senator Furner.

Senator FURNER—I want to ask some questions in relation to page 2 of your submission and the requirement sought for persons who are injured or who have been manipulated by the hands of unqualified or unregistered persons, such as masseurs, naturopaths or Chinese medicine practitioners—not by your members but by other chiropractors who practice natural therapy and/or Chinese acupuncture medicine. I take it that you would support their being under the scrutiny that you are seeking here today should they—and I am not suggesting for one moment that they do—practice those techniques without being qualified.

Dr Crean—The stance that the chiropractors registration boards have taken is fairly well established in our codes of conduct around the country, which is that, for any practice that a chiropractor performs in their clinic that is within the undergraduate program, they need to have completed the appropriate course of training or courses of training to be competent to perform it. If they do not and they perform those activities, they would be subject to disciplinary proceedings upon receipt of a complaint.

Senator FURNER—The Chiropractors Association gave examples of some cases where people had been injured or, in some worse case scenarios, killed as a result of malpractice through manipulation. Are you in a position to provide us with any further indication of examples such as those? I am sure you would have read their submissions.

Dr Crean—The Chiropractors Association has included a number of cases and referenced some of it well. The Chiropractors Association has access to guild insurance records of all the malpractice claims that have been brought against chiropractors in Australia. As boards, we would have to have good reason to try and obtain that information. The registration boards, however, would have the ability to produce a document which would outline some of the complaints that have been brought to them, and that is usually contained in the annual reports that we provide to each of our state governments. I do not know if that answers your question.

Dr Cowie—Within the last eight weeks in New South Wales, we received a complaint from a lady who was injured by a Chinese masseur sort of person—the person that you come across in shopping centres offering \$5 massages. She was taken into a room and her spine was manipulated, and she experienced severe pain as a result. She has made a complaint to the New South Wales Chiropractors Registration Board. The board is currently investigating that incident with a view to prosecuting under the New South Wales Public Health Act, which is where the restriction lies in New South Wales.

Senator WILLIAMS—Just on that issue of chiropractic boards having complaints made to them about people incurring injuries from spinal manipulations performed by unregistered practitioners: do you get many of those complaints about unregistered practitioners, apart from the one you just mentioned?

Dr Crean—I can answer a little about that. In Tasmania, in the first couple of years that I was on the board—and I have been on the board for five years—we would get one to two complaints per year whereby patients would identify a non-chiropractor who had performed, to all intents and purposes, a spinal manipulation. One was mid back, one was low back and one was a generalised spinal manipulation. However, the board could not proceed because the patients were not prepared to put their complaint in writing, and so we had to discharge it.

Senator FURNER—On another issue, you are obviously very concerned about the lack of representation of your organisation, especially in Tasmania, in relation to the establishment of the National Registration and Accreditation Scheme. Do you have any solution for that? What is your opinion?

Dr Crean—The boards as a whole—particularly the smaller boards—had argued the case for one nominee from each state and territory to be on the new national registration board. The solution, sadly, was to look at 12-person boards, which would mean one member from each state and territory on a national board. It would then require three consumer representatives, which would take it up to a 12-person board. I am sorry: that might have been four consumer reps to keep the ratio that had been proposed. That is the only way I can see that working.

I can understand the concern that the bigger the board the more unwieldy it can sometimes become and also the cost tends to go up. However, the proposed board structure would mean that there would be six representatives of the profession from around the country. One would represent a combined ACT, NT and Tasmania. This is across all of the health professions. For example, we recognise that we are a small profession in Tasmania. Let us assume that, for the first term, there was no representation from Tasmania on any of the health professional boards. Suddenly, there are between 10,000 to 12,000 health professionals in Tasmania who have no direct input into the way in which their regulatory body works and also there is no formal

conduit for those people to the health minister because we may not have the committees and state boards for some of the smaller professions. So what has been working very well and enabling us some input into the way in which the codes of conduct are managed and also some input into various other national board matters we will lose.

Senator ABETZ—Can I disclose that Dr Crean is known to me both personally and professionally. Could I ask about the issue of the ethical standards that apply to public health facilities as opposed to private practitioners.

Dr Crean—One of the concerns we have to raise in our submissions—and I guess this is part of the reason why we have to raise the issue of all stakeholders having the ability to read a second draft of the bill—is at the moment there is a section in bill B—and I do not recall the exact section—whereby as a chiropractor and an employer I cannot ask one of my fellow colleagues to perform a task or duty which would be in breach of the proposed bill or in breach of the proposed code of conduct, because that would be an offence in its own right; however, the bill says that a public health facility is exempt from that clause. Firstly, there is no definition of what a public health facility is, so that could mean every clinical practice of any practitioner in the country as a start or it might mean hospitals only, but it is not defined; and, secondly, any public health facility owner or board could ask any of their professional staff members to do things which are in contravention of the new act and they would have impunity to do so.

That is one of the many things that we have to seriously sort out in our submission. Hopefully, it will be picked up by many of the other boards. This is potentially a very serious oversight. If boards and consumer groups do not have the chance to look at the second draft, it would be quite a serious error to not have these things sorted.

Senator BOYCE—That point has not been raised with us before, so that is quite interesting. One hopes it will go into your oversights or errors column.

Dr Crean—It is on the list.

Senator ABETZ—The other matters I wanted to ask about have been adequately canvassed, so thank you very much.

CHAIR—Is there anything that we have not covered that you particularly want to put on the record?

Dr Cowie—I am happy we have covered the material. The submission is in detail and can be referred to to cover all the information that we tender.

Mr Shobbrook—Including the submission that we will be putting in by the end of the week to the national registration body.

Dr Crean—I feel we have received your attention and I am very pleased for your insightful questions.

CHAIR—Thank you very much. I thank Hansard and the secretariat.

Committee adjourned at 5.04 pm