

Review of Regulation of the Health Professions in Victoria

Options for structural and legislative reform

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1. Introduction

In October 2002, the Victorian Department of Human Services ('the Department') commenced a review of the regulatory framework governing the registered health professions in Victoria ('the Review'). The current model of regulation was introduced in 1993-94, and it was considered timely to review how well the scheme protects the public and ensures that health professionals are properly trained and practise in a safe, competent and ethical manner. The Review's aims are:

- ♦ To ensure an up to date and responsive regulatory framework for the Victorian health professions that equips health practitioner registration boards to protect the public and address emerging challenges.
- ♦ To promote consumer and community confidence in the operation of the regulatory scheme.
- ♦ To ensure good links between mechanisms that ensure practitioner quality and those that ensure health system quality.
- ♦ To promote administrative and technical efficiency in the operation of the regulatory arrangements¹.

Guiding principles for the Review were set out in the discussion paper released for public comment in 2003. The Minister for Health, the Department and the registration boards have a shared responsibility for ensuring the principles of **accountability, transparency, fairness, effectiveness, efficiency, flexibility** and **consistency** are given effect to.

Purpose of this paper

Extensive consultation has occurred and a wide range of potential reform options have been canvassed with stakeholders². Prior to finalising recommendations for reform for consideration by the Minister for Health, the Department considers it desirable to conduct further targeted consultations with stakeholders.

Although the Review has also examined issues associated with the unregistered health professions (Part E of discussion paper), this paper focuses on options for reform in relation to the registered health professions only. It is expected that once details of the proposed reforms are finalised in relation to the registered health professions, the Department can turn its attention to regulatory reforms that are required (if any) to the unregistered health professions.

The reform options under consideration can broadly be grouped into reforms to the structure of the regulatory model, and reforms to the provisions contained within the model. This paper has been developed to facilitate dialogue with stakeholders on the broad structural reform options. It provides a brief summary of the findings of the review and the views of stakeholders in response to the discussion paper, as well as:

- ♦ Potential structural changes to the system that could be introduced to address these.
- ♦ A series of proposals for reform to the model provisions that regulate health professionals in Victoria.

The paper is **not** intended to provide a comprehensive report of the outcomes of the consultation, nor provide a detailed response to every issue that was canvassed in the discussion paper.

In this context, stakeholders are encouraged to review the issues canvassed in the Review discussion paper as well as the submissions made which are available to view on the Department's website at http://www.dhs.vic.gov.au/pdpd/workforce/pracreg/sys_review.htm. It is envisaged that a further round of meetings with key stakeholders will occur over April 2005 to present outcomes of the public consultation process and discuss policy recommendations.

The proposals in this paper do not represent the views of the Minister for Health or the Government. They have been developed as draft reform proposals by the Department. The paper will provide a basis for discussions with stakeholders before recommendations for reform are finalised for consideration by the Minister for Health.

While the legislative reform program is determined by the Victorian Cabinet in light of many competing priorities, at this stage it is planned that, subject to Ministerial and Cabinet endorsement, amendments required to Victorian health practitioner registration acts arising from recommendations of this Review will be put to the Victorian Parliament in its Spring 2005 session.

¹ This objective was not flagged explicitly in the discussion paper released in October 2003 but has been added in this report in part as a response to requirements on State Government departments issued by the newly established Victorian Competition and Efficiency Commission.

² A summary of the review process is provided in Attachment 2.

2. Outcome of Consultation – Key Findings

The Department acknowledges that registration board members and their staff are highly committed people who take their roles very seriously and are dedicated to their task of protecting the public. Many board members work extra hours unpaid, and some restructure their work commitments in order to carry out these public service roles. The system is reliant on the ability of government to continue to recruit individuals of high calibre with the professional expertise as well as the commitment to public service required to carry out these challenging roles. The Department would like to recognise their contribution.

The Review has identified a number of concerns about the current regulatory system where improvements could be made. These are:

- ♦ A cumbersome and inefficient legislative framework.
- ♦ Poor separation of powers in disciplinary processes.
- ♦ Some lack of consumer confidence in the transparency and fairness of complaints handling.
- ♦ Some inefficiency and duplication in administration.
- ♦ Workforce inflexibility and poor practitioner/service quality linkages.

A cumbersome and inefficient legislative framework

Whilst the application of a model Act has promoted a relatively high level of consistency between legislation, not all Acts have been updated to incorporate the most modern provisions contained in the *Pharmacy Practice Act*³

As a result, most registration boards do not have all the powers required to adequately protect the public and deal with poor practice. The effectiveness of registration boards is less than optimal without such powers.

One of the challenges for Government is to ensure that the legislative framework is effective, flexible and responsive to emerging challenges. Given the competing priorities on the Government's legislative reform program, relatively minor amendments to single Acts are often unable to gain priority on the program. Under the current scheme, it is a highly resource intensive task for Government to keep all Acts up to date, and there is considerable lead time between when a reform is introduced in one Act, and when it is applied to the remaining 11 Acts.

Poor separation of powers in disciplinary processes

Under the current legislative arrangements, each registration board is responsible for all stages of the complaints management and disciplinary process. This system has potential to compromise procedural fairness for complainants and practitioners and is contrary to principles of natural justice.

All boards are aware of such problems with the model and make efforts administratively to separate these functions, and to ensure that board members who have any involvement in the investigation of a complaint, or the initial decisions about whether to proceed to hearing do not, then, sit on a hearing panel.

However, there is a need for improvements to achieve a better 'separation of powers' particularly between the functions of investigation/prosecution, and hearing/determination.

Lack of consumer confidence in the transparency and fairness of complaints handling

Registration boards derive their authority from a delegation of the power of the state, conferred by the Victorian Parliament. Under the current model, there are a number of mechanisms through which registration boards are accountable for the exercise of their functions⁴. These mechanisms provide a broad accountability framework within which registration boards operate. However, they do not provide for accountability and transparency in the many day to day decisions that registration boards make, nor do they address many of the concerns raised by consumers who challenge the peer review nature of the regulatory model, believing the registration boards as 'subject to capture' by the professions.

At times, resolution of a complaint to the satisfaction of the complainant may not be in the best interests of the service system as a whole⁵. The interests of the health system may be better served by ensuring practitioners are supported to improve their practice and address any deficiencies, rather than imposing

³ With the exception of the Health Act (that provides for the registration of medical radiation technologists), there are standard provisions in all Victorian registration Acts that establish common powers in relation to registration processes, complaints handling and discipline. More than ninety percent of the provisions in each registration Act can be considered to be 'template' or 'model' provisions.

⁴ These include annual reports and audited financial statements, and rights of review to the Victorian Civil and Administrative Tribunal, for certain board decisions.

⁵ There are inherent tensions in the model, where the role of registration boards is to act to protect the public by addressing unprofessional conduct, rather than to 'resolve' complaints. Similar to the criminal jurisdiction, the complainant is a witness in the board's case rather than a party with certain rights in the process.

sanctions, punishments or suspending or cancelling a practitioner's registration. However, there are increasing demands for more accountability and transparency, in the form of more public interest input into all regulatory decisions and rights for independent review of board decisions.

A commissioned study of complainants to five registration boards documented some concerns with the current arrangements, including long timeframes to settle complaints, perceived lack of procedural fairness and no formal appeal rights for complainants. The Ombudsman has also highlighted concerns from time to time about registration board complaints handling processes, particularly in relation to level of consistency, transparency and accountability⁶.

Inefficiency and duplication in administration

While three of the smaller boards have registrar and administrative services provided by the same accountancy firm, there continues to be duplication of effort in the operation of separate registration board administrative units. This duplication of effort is reflected in increased costs associated with maintaining physical infrastructure, developing policies and procedures, and sourcing legal and investigation expertise.

Such administrative arrangements are inefficient and costly, with costs ultimately borne by consumers. However, more significantly, these arrangements do not facilitate sharing of important expertise across boards, or the establishment of consistent processes for managing common statutory functions.

Workforce inflexibility and poor practitioner/system quality linkages

Existing profession specific registration legislation and governance structures reinforce rather than break down professional boundaries and do not foster a multi-disciplinary, flexible and responsive workforce. This makes workforce change in response to evolving service and client needs contested and slow. At the same time, the existing regulatory model does not facilitate good linkages between mechanisms that ensure practitioner quality with those that ensure system quality. Exploring opportunities to improve this is important, particularly given that Health Ministers have identified quality and safety as a priority area for health sector reform.

With significant workforce shortages predicted for the coming decades, it is essential that the regulatory arrangements not only support acceptable standards of training and practice for the existing professions, but also facilitate quality improvement and workforce change where required. If the workforce is to be equipped to respond to the health needs of the population in the 21st century, then the regulatory structures must adapt accordingly.

⁶ These centred around current arrangements for the conduct of hearing panels and review of decisions, and included issues around options for hearing panels to revisit or review decisions, the rights of complainants to a statement of reasons for decisions made by registration boards and hearing panels and the need for increased public input into decision making.

3. Model of Regulation

Purposes and model of legislation

The discussion paper invited comment on six models for regulation of the health professions, ranging from self-regulation through to protection of title and reservation of practice (chapter 3).

Submissions generally supported protection of title only as the model of legislation, with some supporting strengthened board powers. Some professional associations and registration boards supported introduction of restrictions on practice.

The Department is of the view that, on balance, it appears the current Victorian model of regulation of the professions based on protection of professional titles provides sufficient public protection from untrained and unregistered practitioners. Additional legislated restrictions on practice are considered unnecessary given that:

- ♦ No firm evidence was presented to the Review to indicate that consumers are suffering harm under the current protection of title arrangements.
- ♦ Additional practice restrictions would inevitably result in demarcation disputes between the professions about their scopes of practice.
- ♦ Practice restrictions are generally difficult to enforce, can be costly and lead to unwarranted workforce rigidities, without providing significant additional protections.

There is, however, a need to clarify the offence provisions to ensure that practice descriptors that are not, technically, being used as professional titles are prohibited from use by unregistered persons. The need for additional restrictions on use of electro-therapeutic equipment is under consideration as part of the Victorian Review of Radiation Safety. Current restrictions on practice in dentistry and optometry are addressed in section 5 of this paper.

Reform proposals

1. *That the current Victorian model of regulation of the health professions, based on protection of title rather than protection of practice, be retained, subject to modifications outlined in this paper.*
2. *That the offences for use of restricted professional titles be amended to ensure that they specifically capture titles when used as practice descriptors rather than as professional titles.*

System Funding

The discussion paper set out the arrangements for funding of registration boards, via fees charged to registrants (chapter 4.3).

There was general support from respondents for the self-funding model for regulation of the professions. However, some expressed the view that Government should make some financial contribution, particularly for the smaller professions, in light of the public protection functions carried out by boards, the cost of community education and the expense of some disciplinary proceedings.

The Department is of the view that there is no reason to change the current principle that registration boards should be self-funding, while retaining the option for Government to contribute financially to certain jointly run projects, for example the Overseas Trained Doctors Training Scheme, and the development of guidelines (such as the infection control guidelines for acupuncture).

Reform proposals

3. *That the existing model of self-funding of registration boards be retained, with provision for shared board/government funding of joint projects as negotiated from time to time.*

Practitioner and system quality linkages

The discussion paper identified the need for strong linkages between mechanisms that ensure practitioner quality, and those that ensure system quality (chapter 9). A range of proposals to enhance linkages were canvassed including:

- ♦ Improved information sharing, particularly in instances where other agencies (such as TAC or VWA) have investigated a practitioner.
- ♦ Improved linkages between credentialing/clinical privileging systems and practitioner regulation.
- ♦ Expanded functions of registration boards to advise where systems failure contributes to unprofessional conduct.

Responses varied as to how the respective bodies involved in receiving complaints and investigating the professional conduct of practitioners might work together. While there was general support for improved information sharing between Victorian government bodies such as the boards, the TAC and VWA, most respondents did not believe this required legislative reform.

The Department is of the view that, while there may be merit in improving information sharing between the Boards and other statutory agencies such as VWA and TAC, legislative reform of health practitioner registration legislation is not required at this time. The Department will, however, continue to liaise with the relevant agencies to identify and deal with any difficulties.

In relation to credentialing and clinical privileging, the majority of respondents supported the status quo. Substantial work is being done at the national level and within institutions to establish standards and guidelines for good credentialing practice. The Department is of the view that, if powers to regulate unsatisfactory professional performance are extended to all regulated health professions (see section 5 of this paper), there will be a need to ensure sensible linkages between registration boards and credentialing bodies. However, given the stage of development of credentialing processes across the health system, good linkages are likely to be better driven through practice and experience rather than through legislation at this time.

There was strong support for a role for registration boards in reporting patterns of poor performance that may indicate systems failure. The Department is of the view that, although the focus of boards is on protecting the public by regulating the standards of training and practice of registered practitioners, there is a role for boards to:

- ◆ Identify any instances of systems failure that may have contributed to unprofessional conduct by a registrant.
- ◆ Make the Minister for Health aware of any concerns about the health system that arise from carrying out these statutory functions.

Section 105(1)(k) of the Pharmacy Practice Act 2004 provides a template.

Reform proposals

4. *That the legislation include a role for all registration boards to report to the Minister any concerns about the health system in Victoria that arise from carrying out their functions.*

Regulation of Midwives

The discussion paper identified deficiencies in the current regulatory arrangements governing midwives and difficulties in dealing with midwives who have graduated from 'direct entry' courses and are not eligible for registration as division 1 nurses (chapter 22).

There was general support for more readily recognisable and appropriate registration of midwives. Midwifery groups have called for a separate legislation to regulate the profession separately from nursing.

The Department is of the view that there is a need for legislative reform to clarify the status of midwifery registration and to provide suitable regulatory controls in relation to midwives who are not also trained as division 1 nurses. The Department notes the approach adopted in NSW with the passage of the Nurses Amendment Act 2003, which:

- ◆ Retitled the Nurses Act as the 'Nurses and Midwives Act'.
- ◆ Established a 'Nurses and Midwives Board'.
- ◆ Established separate registers for nurses and midwives.

Should profession specific boards be retained, the Department does not support the establishment of a separate 'Midwives Board'. A single 'Nurses and Midwives Board' is preferable, provided that within the structure of such a combined board there is provision for sufficient discipline specific input.

Although NSW experienced a number of high profile professional misconduct cases involving midwives in the 1990's there is no evidence of similar problems in Victoria. Therefore, the introduction of a practice restriction similar to that which applies in NSW and Queensland⁷ is not warranted at this stage.

Reform proposals

5. *That the legislation make provision for separate registers of nurses and midwives, and, if profession specific registration boards are retained, a single 'Nurses and Midwives Registration Board'.*
6. *That there be provision within legislation for the establishment of statutory committees to provide access to specific expertise for nursing and midwifery where required.*

⁷ Section 10AG of the NSW Public Health Act restricts who can manage labour and undertake the delivery of a baby. Similarly restrictions apply in Queensland, see section 771 of the Nursing Act 1992 (as amended by the Health Legislation Amendment Act 2005).

Regulation of Medical Radiation Technologists

The discussion paper summarised arrangements under the Health Act and Regulations that provide for registration of medical radiation technologists (chapter 3.4.3). The Review of Victorian Radiation Safety Legislation Discussion Paper (2003) also addressed how medical radiation technologists should be regulated (chapter 7).

There was general support for continued registration of medical radiation technologists but via the same legislative scheme that is to apply to all the registered health professions rather than via the Health Act and Health (Medical Radiation Technologists) Regulations. Some respondents called for sonographers who are not captured under current registration requirements to be brought within the scheme.

The Department is of the view that registration of medical radiation technologists is required in order to protect the public, this profession should be brought within the legislative scheme that applies to all registered health professions. Any proposed extension to the scope of the regulatory scheme in Victoria to cover, for example, sonographers, should be addressed in cooperation with other jurisdictions through the Australian Health Ministers Advisory Council and the Australian Health Workforce Officials Committee.

Reform proposals

7. *That the legislation make provision for registration of medical radiation technologists and repeal the Health (Medical Radiation Technologists) Regulations and any relevant provisions of the Health Act.*

4. Options for Structural Reform

Consistent with the principles underpinning this review, it is essential that any proposed reforms:

- ♦ Retain the best elements of the system as it currently operates, including access to essential professional expertise.
- ♦ Ensure best use of board resources in the public interest.
- ♦ Provide procedural fairness for all parties in any complaints handling processes.
- ♦ Ensure consistency with broader legal/regulatory principles.

The inherent tensions in the regulatory model mean that affording procedural fairness in all registration board decisions is a significant and critical challenge. The decision making of registration boards must not only be fair, but must be seen to be so. In considering any proposed reform, particularly to the complaints handling processes, it is essential to balance the rights and aspirations of complainants (a proportion of whom can never have the complaint resolved to their satisfaction) with those of the practitioner and the health system as a whole.

There are five main options for reforming regulation of the health professions. They vary in the degree of structural change that would be made to the regulatory system.

An up to date and responsive regulatory framework

Option 1A: Update the template provisions

Under this option, a range of reforms to administrative and governance arrangements could be implemented (such as those outlined in sections 5-10 of this paper) to promote greater transparency and accountability in board operations generally, and complaints investigation and disciplinary processes in particular.

Reforms to improve the administrative and governance arrangements could include, for example:

- ♦ A statutory 'Investigations Committee' of the board to make investigations decisions currently required to be made by the full board. This could allow internal rights of review of decisions and better 'separation of powers' between functions of investigation/prosecution and hearing/determination.
- ♦ Mandatory timeframes in which boards must complete certain stages in complaints management and disciplinary matters.
- ♦ A statutory requirement for boards to provide complainants and registrants with written reasons for decisions following preliminary investigation or informal hearing.
- ♦ Statutory powers to change the composition of Boards and/or hearing panels to change the balance of practitioner/non-practitioner membership.

Option 1B: A single 'Health Professionals Registration Act'

An alternate option would be to enact an "umbrella Act" whereby:

- ♦ 12 separate registration Acts would be repealed with the passage of a single 'Health Professionals Registration Act'⁸;
- ♦ 12 separately constituted registration boards would be retained and professions currently regulated under the Health Act and Health (Medical Radiation Technologists) Regulations 1997 would be brought within the regulatory scheme.

These boards would have common core powers and functions, and would maintain (as under the current system) their own offices and administrative arrangements.

Under either option, it is considered that updating of the model provisions is necessary (see sections 5-10 of this paper).

Improved transparency and accountability for decision-making

While the proposals outlined under Option 1 could be expected to address some concerns identified in the Review, there may continue to be a perception that the regulatory bodies are 'subject to capture' by the professions and that their decision making is not sufficiently transparent or fair. There are a number of reforms that, if implemented, might improve the separation of powers between investigation/prosecution and hearing and/or establish independent rights of review for various board decisions.

⁸ The Pharmacy Practice Act 2004 would be the template as it contains the most up to date provisions. Where profession specific legislative provisions are required, these would be contained in schedules to the umbrella Act.

If separation of powers is improved, there may be less need for external appeal (as external scrutiny is effectively built into the system).

Option 2A: A separate 'Health Professions Tribunal'

An option to achieve a better separation of powers would involve establishment of a 'Health Professions Tribunal' to conduct hearings into unprofessional conduct of a serious nature. Such a tribunal would have powers to:

- ♦ Hear matters brought by a registration board involving allegations of serious unprofessional conduct that, if substantiated, may provide grounds for suspension or cancellation of a practitioner's registration (the equivalent of the current formal hearing).⁹
- ♦ Ratify a decision by a registration board informal hearing panel (or equivalent) arising from conduct, performance or ill-health processes, that a practitioner's registration be suspended or cancelled, where all parties are in agreement.
- ♦ Hear appeals from practitioners concerning:
 - a decision of a registration board informal hearing panel (or equivalent) concerning matters of conduct, performance or health, or
 - a registration board decision to refuse registration, renewal of registration, or to impose conditions on a practitioner's registration (as under current arrangements).

To ensure appropriate expertise is available and to provide a balance of professional, legal and community perspectives in the decision making process, any such tribunal would need to typically comprise a panel consisting of a legally qualified person (who would also act as Chair of the panel), a non-practitioner and two practitioner members from the relevant profession.

The boards would continue to investigate and present cases to the tribunal in a manner similar to the way they present to a formal hearing. Costs of tribunal hearings would be apportioned to registration boards on a user pays basis. There are two alternative models for the tribunal:

- ♦ A stand alone specialist tribunal; or
- ♦ A separate list within the Victorian Civil and Administrative Tribunal (VCAT), similar to that to be established for the legal profession under the recently passed Legal Profession Act.

Both options would result in an increase in costs. A stand-alone tribunal is likely to be more expensive than a separate health professions list within VCAT, due to the economies of scale afforded in VCAT. For some professions there could be a resultant marginal increase in registration fees.

A separate 'Health Professions Tribunal' is consistent with the trend interstate and internationally, to separate this function from registration boards. Such a tribunal would provide independence and greater consistency in decision making in serious matters and the judicial input would address some of the issues identified by the Ombudsman and complainants. Involving practitioner members would however be essential to the effectiveness of such a model, to ensure a full understanding of the professional issues being considered. Figure 2A, overleaf, provides a diagrammatic summary of how this model might operate.

Option 2B: Reform of investigations function

An alternative option would involve the Health Services Commissioner (HSC) assuming statutory responsibility to receive and investigate all consumer complaints¹⁰ and determine what action is required following the investigation. Under this option all registration boards, when they receive a complaint from a consumer, to refer the matter straight to the HSC without first conducting a preliminary investigation. Following investigation of a complaint, the HSC might refer the matter:

- ♦ for conciliation; or
- ♦ to the Police if it involves a criminal matter; or
- ♦ to a formal hearing (by a board or Tribunal) if it is potentially serious enough to warrant suspension or cancellation of registration; or
- ♦ to the relevant board to be dealt with through the performance or ill-health pathways.

When referring a matter to a formal hearing or equivalent, the HSC would, in effect be responsible for the 'prosecution' function. This option is summarised in Figure 2B, overleaf.

Moving responsibility for investigation of complaints to the HSC has the advantage of providing single point for consumers to lodge complaints, and independence in complaints investigation. It would maximise

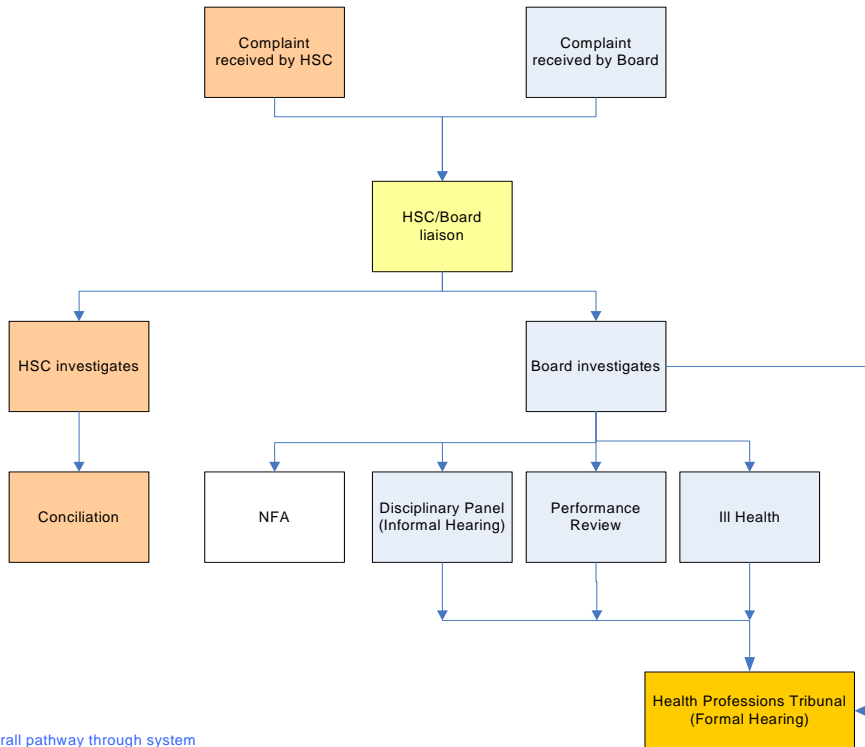
⁹ The boards would continue to have the power to immediately suspend a practitioner's registration pending formal processes. The tribunal would have the power to ratify agreements reached between a board and a practitioner following conduct, performance or ill-health board processes, to suspend or cancel the practitioner's registration.

¹⁰ Self-referrals and notifications from colleagues or employers, for example about the health of a practitioner, would continue to be directed to and investigated by the relevant registration board, without the involvement of the OHSC.

consistency in management of consumer complaints, and make the task of community education about where and how to make a complaint less costly and more effective.

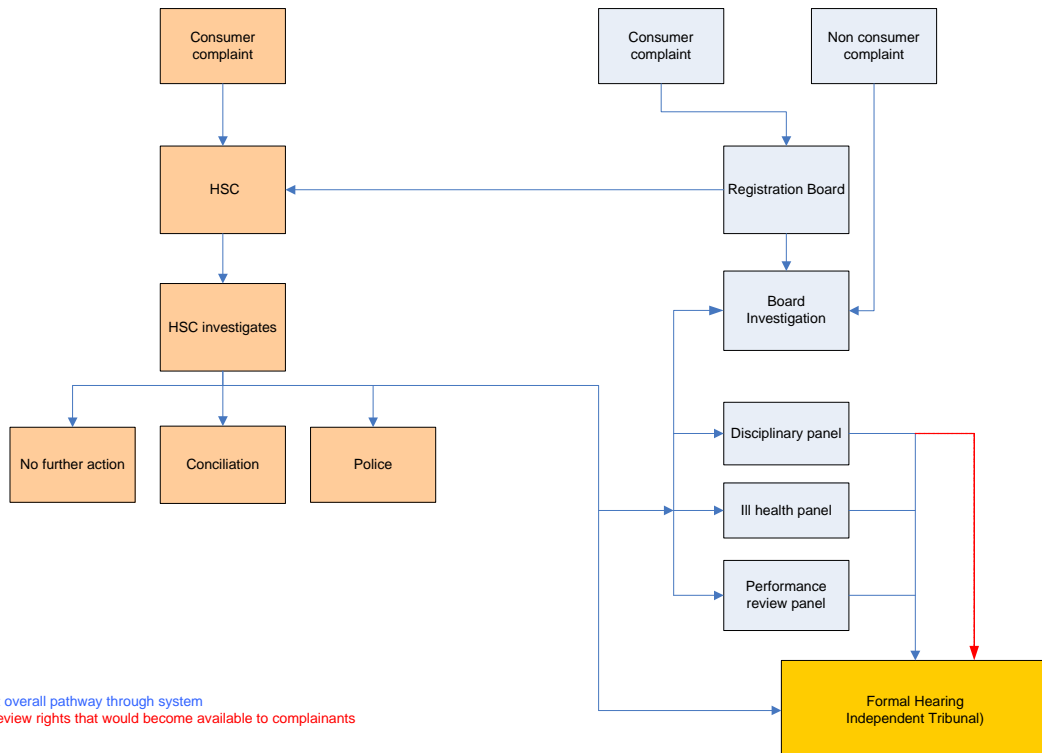
Changes, however, to the jurisdiction of the HSC to establish a role in 'prosecuting' complaints before a tribunal or hearing panel, as occurs with the NSW Health Care Complaints Commission, has the potential to compromise its ability to effectively conciliate complaints. Such a model would also need to ensure there was sufficient profession specific input to the management of complaints that relate to professional standards.

Figure 2A – A separate Health Professions Tribunal



Blue lines represent overall pathway through system

Figure 2B HSC assumes responsibilities for investigating complaints



Blue lines represent overall pathway through system

Red line identifies review rights that would become available to complainants

Enhancing consumer confidence in complaints handling

Although the Ombudsman has been quite effective in recent years in scrutinizing registration boards' complaints handling processes, unless an independent review of the merits of a board decision is available to complainants, some will continue to be aggrieved due to a perception of bias. At the same time, there is a need to ensure the practitioner is not subjected to unnecessary stress and expense associated with a 'querulous' complainant.

The options to enhance rights of review would be in addition to existing review powers of the Ombudsman, and the capacity to seek the intervention of the Supreme Court on administrative law grounds.

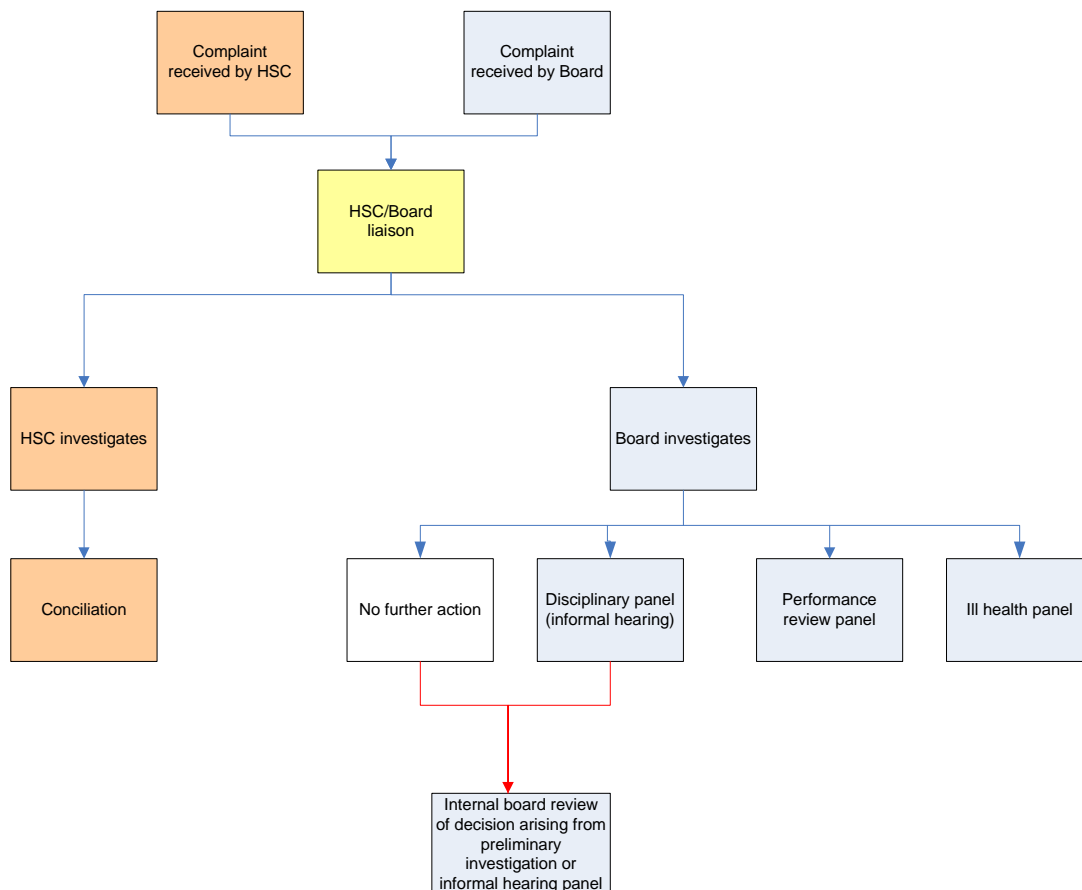
Option 3A: Internal board review

This option would establish an internal right of review, allowing an aggrieved complainant to seek a review to a panel of the board following a preliminary investigation or an informal hearing panel. The review panel could include community (non-practitioner) as well as practitioner members, and a nominee of the HSC. Any individual who had participated in the investigation/hearings process could not sit on a panel to review the matter.

Internal review by a board could provide a further level of scrutiny of the investigations/informal hearing function, while preserving the essential function of the board to address deficiencies in practice in the public interest rather than to 'resolve' complaints to the satisfaction of individual consumers. It would be administratively efficient since it allows boards to address any shortcomings in their processes, rather than relying on the Ombudsman to identify deficiencies. However, an internal review is unlikely to satisfy those complainants who do not feel the boards are sufficiently independent.

Figure 3A provides a summary of how such a proposal might operate.

Figure 3A: Internal review by Board



Blue lines represent overall pathway through system

Red line identifies review rights that would become available to complainants

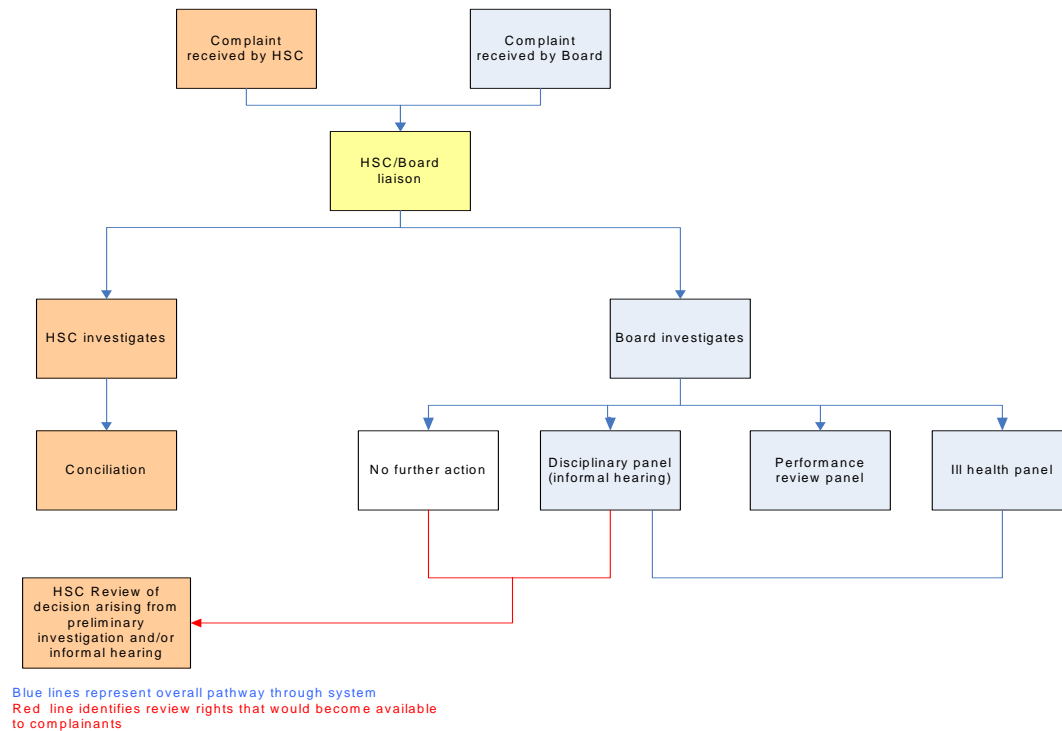
Option 3B: External review by Health Services Commissioner

Under this option, the legislation could make provision for a complainant to seek a review of decisions arising from preliminary investigations and/or informal hearings to the HSC.

The HSC would have the power to examine the evidence, and in relation to a determination following investigation, either refer the matter back for the Board to further investigate, or substitute her own decision from the range of decisions open to the board following investigation. In cases where the HSC had prior involvement with the complainant, the legislation would require that the person who reviews the decision to have had no prior involvement in the matter.

Figure 3B provides an overview of how an external review to the HSC might operate

Figure 3B: External review by Health Services Commissioner



Option 3C: External review by VCAT/Health Professions’ Tribunal

Under this option, complainants could seek an independent review of board decisions arising from preliminary investigations and/or informal hearings to VCAT or a Health Professions’ Tribunal. These bodies would have the power to undertake a merits review and substitute their own decision.

The options of establishing an external review by the HSC, VCAT or a Health Professions’ Tribunal would be more costly, but would provide more independent scrutiny. Both boards and practitioners may incur additional costs in defending decisions where the complainant disagrees.

Figure 3C on the next page provides an overview of how an external right of review might operate.

Promoting administrative and technical efficiency

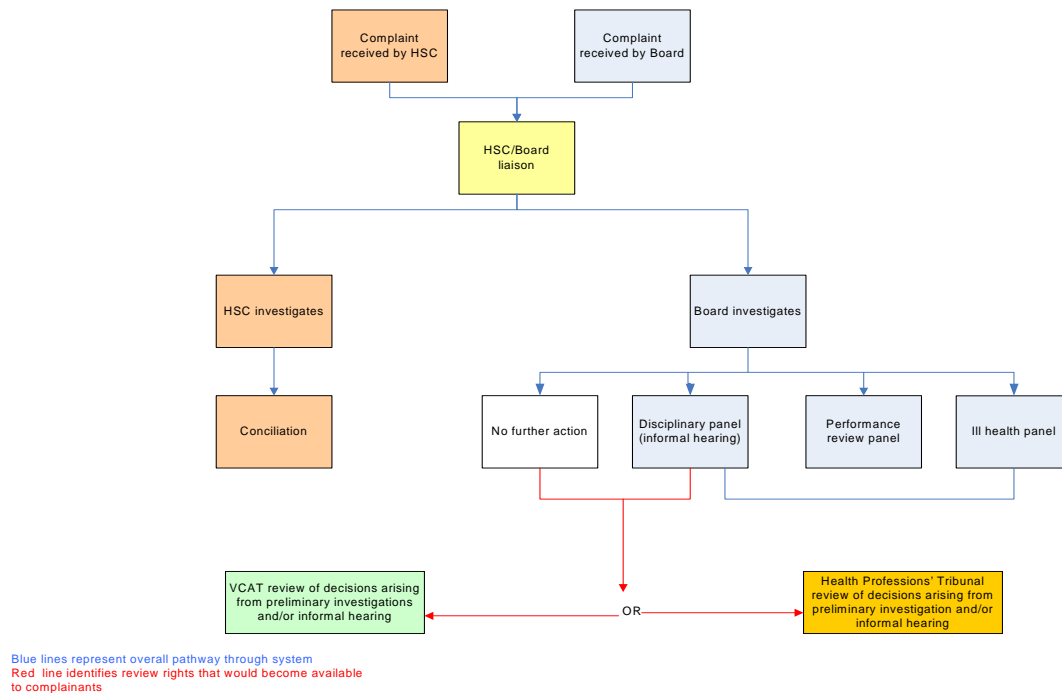
Option 4: A single ‘Office of the Health Professions’

Under this option, the legislation would provide for the establishment of a single statutory office, the ‘Office of the Health Professions’ (‘the Office’). The role of the Office would be to provide administrative support to all the registration boards, in place of the 10 separate board administrations that currently operate¹¹. A single administration exists in Queensland and in NSW (although this administration operates from within the Department of Health) and in Victoria three boards already share the same registrar and office.

Consolidating administrative arrangements could promote greater consistency and efficiency in maintenance of the registers, provision of public information and publication of board guidelines in common areas and allow cross profession issues such as scopes of practice to be addressed more flexibly. If such an option were implemented, co-location of board administrations could occur over time, and rationalisation of staffing (if any) could be managed by natural attrition.

¹¹ The Office could negotiate a service agreement with each registration board that would specify the administrative support to be provided and the associated resourcing requirements.

Figure 3C: External review by HSC or Tribunal



Ensuring a responsive and system quality focused workforce

Option 5: A single 'Health Professions Council'

Under this option, a single 'Health Professions Council' under a single Act would replace the 12 separate registration boards. The Council could be modelled on the United Kingdom's Health Professions Council that registers over 156,000 health professionals in 13 separate health professions. The Council would be empowered to carry out the same functions as registration boards, with the exception of the formal hearing function.

Under this option:

- ♦ The model provisions would be updated (as for Option 1A);
- ♦ A single 'Health Professions Registration Act' would replace the 12 separate registration Acts (as for Option 1B);
- ♦ The formal hearing function would be handled by a separately constituted 'Health Professions Tribunal' (as for Option 2A);
- ♦ The administrative support for all registration boards would be consolidated into a single 'Office of the Health Professions' (as for Option 4);
- ♦ A single 'Health Professions Council' would replace the 12 separate registration boards.

Under the proposed model there would be:

- ♦ A Council made up of 12 registrant members, one for each regulated profession, up to 8 'lay' members and 3 lawyer members.
- ♦ Statutory 'Registration and Standards Committees', one for each regulated health profession. These committees would carry out the statutory functions of registration of practitioners (and course approval where relevant), as well as develop profession specific standards and guidelines for ratification and release by the Council.
- ♦ A single 'Investigations Committee' to receive and investigate complaints & notifications relating to ill-health, unsatisfactory professional performance or unprofessional conduct;
- ♦ A single 'Professional Standards Committee' to deal with matters referred from the Investigations Committee relating to professional conduct or professional competence;
- ♦ A 'Health Committee' to deal with matters referred from the Investigations Committee (or a panel sitting as the Investigations Committee) relating to assessment & monitoring of practitioners suffering ill-health or drug or alcohol addiction.

Each of these Committees would have a core membership of lay and legal members, with capacity to co-opt practitioner members as required to provide the profession specific expertise.

The Governor in Council, on recommendation of the Minister for Health, would appoint all members of the Health Professions Council and a list of persons (practitioners, lay and legal members), who would then be available to be appointed by the Council to the various positions on the statutory committees and expert panels. Membership numbers and categories for each statutory committee would be set in legislation, but with capacity for the Chair of each committee to co-opt practitioner members to provide the profession specific expertise or constitute profession specific panels as required.

This model would improve the consistency of regulatory arrangements across the registered health professions and facilitate implementation of best practice regulation. It would also better support the development and deployment of a more flexible multi-skilled workforce by reducing demarcation disputes between professions and facilitating implementation of more flexible scopes of practice. It could improve transparency by consolidating reporting arrangements for all the regulated health professions, improve procedural fairness of processes, simplify arrangements for consumers and improve confidence in the independence of the regulatory system.

5. Registration

Temporary and area of need registration

The discussion paper outlined current arrangements for registration and provisions in other jurisdictions (chapter 14.2).

There was widespread support for provisions for temporary registration. Many called for such registration to be conditional, based on equivalent qualifications and of a limited timeframe.

The Department is of the view that there should be more flexible legislative powers for registration boards to provide temporary registration subject to conditions, in response to various circumstances, including practitioners visiting from interstate and overseas for short periods, and to address workforce shortages in areas of need. There is also a need to streamline registration arrangements for interstate practitioners.

Amendments are currently being drafted for introduction in Autumn 2005, extending powers to all boards in relation to 'identified need' registration. The work being done under the AHMAC National Medical Registration Legislation Project to establish a system of portable medical registration should provide a model that can be adopted across the registered health professions in Victoria.

Reform proposals

8. *That the legislation include provisions to enable the granting of temporary registration to interstate or overseas trained practitioners in response to specific service need.*

Student registration

The discussion paper outlined student registration provisions that currently apply to medical students, and canvassed views on whether such provisions should apply across all the registered health professions (chapter 14.3).

There was general support for the registration of students in clinical settings, but some saw responsibility as residing solely with clinical and educational supervisors, with no role for registration boards.

The Department is of the view that registration of students has a number of advantages. It provides:

- powers to deal more effectively with students suffering from ill health or drug dependence; and
- a vehicle for educating students on the statutory framework within which they will be working and the responsibilities they will face once registered.

Reform proposals

9. *That the legislation include discretionary powers for all registration boards to register students along the lines of the provisions contained in the Pharmacy Practice Act 2004.*

Interim registration

The discussion paper canvassed views on the need for a form of interim registration to be granted by the registrar pending consideration by the board (chapter 14.4).

There was strong support for interim registration from most stakeholders. There were some qualifiers, including that it should be time limited, that interim registrants should comply with full registration requirements and there is supervision to ensure quality of practice.

The Department is of the view that powers to grant interim registration are important to facilitate efficient administrative processing of registration applications.

Reform proposals

10. *That the legislation be amended to include provisions that allow for interim registration.*

Non-practising registration

The discussion paper canvassed views on the need for a category of registration for practitioners who are not currently in practice (chapter 14.5).

There was general support for non-practising registration provisions it would makes transparent arrangements that otherwise would not be subject to board scrutiny, allow practitioners who have left the workforce to retain a link with their profession and encourage a return to active practice at a later date and allows registration boards to more actively regulate return to practise.

Reform proposals

11. *That the legislation include provisions that allow registration of practitioners as 'non-practising'.*

Specialist registration

The discussion paper outlined various models for regulation of speciality practice (chapter 14.6).

There was widespread support for a publicly available register of specialists. Some submissions also supported legislative restrictions to regulate use of the title 'specialist'.

The Department is of the view that the preferred model is where registration boards enter recognised specialist qualifications on the public register.

Reform proposals

12. *That the legislation include provisions that allow the entry of recognised specialist qualifications on the practitioner registers.*

Qualifications requirements for registration

The discussion paper outlined issues with qualifications requirements for registration (chapter 14.7).

Respondents were divided on the need for statutory principles to guide registration boards in approving qualifications for registration purposes. There was general opposition from professional bodies to any role for the Minister in approving (or prescribing in regulation) recognised qualifications for registration purposes.

The Department is of the view that it is in the public interest for there to be safeguards in place in the event that a registration board unilaterally and without sufficient consideration of workforce and service delivery implications, increases to an unsustainable level the statutory requirements for registration of practitioners or issues practice guidelines that introduce unnecessary workforce rigidities. Ministerial power to prescribe qualifications for registration exists in other jurisdictions, and existed in Victoria prior to 1993.

Reform proposals

13. *That the legislation include a provision that empowers the Minister for Health to prescribe qualifications for registration purposes, following consultation with relevant registration boards, educational institutions and qualification assessment and approval authorities,*

Nationally consistent registration arrangements

The discussion paper outlined the challenges of regulation of the health professions under a federal system, and recent developments to establish national processes in areas such as course accreditation and recognition of overseas trained practitioners (chapter 10).

There was strong support from stakeholders for nationally consistent registration and a nationally agreed consistency in qualifications that are recognised for registration purposes. This is consistent with what was agreed by Health Ministers in April 2004 to achieve nationally uniform medical registration arrangements.

The Department supports the establishment of nationally based structures and processes for the registration and regulation of the health professions.

Reform proposals

14. *That the outcomes of the Australian Health Minister Advisory Council (AHMAC) project to develop nationally uniform medical registration arrangements be used as a template for pursuing discussions with other jurisdictions regarding a nationally uniform approach to registration of all health professions.*

Public access to register information

The discussion paper outlined issues associated with public access to information about registered practitioners (chapter 8). Views were mixed about public access to information about registrants that is kept on practitioner registers. In general, practitioner respondents supported less information being available due to concerns about their privacy, and consumers wanted more information in order to make more informed decisions when choosing or using a practitioner.

The Department is contributing to the AHMAC project to develop nationally uniform medical registration arrangements. This project includes the development of a nationally agreed standard for public access to medical register information. Some initial policy recommendations arising from this process were taken into consideration when drafting the provisions of the Pharmacy Practice Act 2004, although further changes may be required to ensure the public has sufficient access to registration information, including conditions, imitations and/or restrictions on registration.

Reform proposals

15. *That the provisions of the Pharmacy Practice Act 2004 provide the template for drafting provisions on public access to register information, ensuring that the public has sufficient access to information regarding the status of practitioner registrations and any conditions, limitations or restrictions.*
16. *That any recommendations for reform arising from the Nationally Consistent Medical Registration Legislation Project be taken into consideration during drafting.*

Information required from registrants

The discussion paper provided an overview of the powers of registration boards to require information on registration, on renewal of registration and during the registration period (chapter 14.9). It also canvassed whether there should be a mandatory requirement for practitioners, on annual renewal of registration, to provide data to be used for workforce planning purposes (chapter 9.7).

Respondents were divided on whether statutory requirements for registrants to provide the boards with information should be strengthened, in addition to the powers contained in the Medical Practice Act and the Pharmacy Practice Act. A number of submissions supported requiring information concerning ability to practice, particularly from those returning to practice after a period of absence.

Most respondents supported mandatory data provision on registration renewal and establishment of unique identifiers, providing it was not onerous on all parties and systems to protect the privacy of individual practitioners are put in place. Views on collecting data for workforce planning purposes were mixed, however, there was general support for data collected to be nationally consistent where possible, and a desire to see analysis of such data made publicly available.

The Department is of the view that registration boards must have sufficient powers to require registrants provide information, not only at annual renewal but also during the registration period. This information:

- has the potential to provide triggers for the board to initiate disciplinary action or a performance assessment of a practitioner where there are reasonable concerns about their competence or fitness to practise; and
- provides a cost effective method of collecting data that is critical to improving workforce planning.

The provisions of the Pharmacy Practice Act 2004 should be used as the template. This Act requires information (either on annual renewal or during the registration period) in relation to professional indemnity insurance, areas of practice, participation in CPD, damages paid for medical negligence, charges or convictions for indictable offences, and any other matters the board considers relevant.

Reform proposals

17. *That the legislation include strengthened powers for boards to require registrants to provide information at annual renewal and during the registration period.*
18. *That the legislation be amended to include a role for registration boards in collecting and supplying data requested by the Minister for workforce planning purposes, and statutory powers to require practitioners complete a de-identified and confidential workforce census as a requirement of registration/renewal of registration.*
19. *That national work on the establishment of unique identifiers and the Index of Medical Practitioners inform such data collections in Victoria.*

Professional indemnity insurance requirements

The discussion paper set out the policy rationale for a role for registration boards in ensuring practitioners have in place suitable professional indemnity insurance (PII) (chapter 14.8).

There was widespread support for extending the professional indemnity insurance powers to all registration Acts. Concerns were raised regarding the level of minimum cover required, competition considerations and the need to control costs.

The Department is of the view that it is in the public interest for registration boards to take a role in ensuring that all registrants have in place suitable professional indemnity insurance arrangements. Amendments have been prepared for consideration by Parliament in Autumn 2005 to extend professional indemnity insurance powers to all remaining boards that do not yet have such powers.

Reform proposals

20. *That the legislation include provisions similar to those in the Pharmacy Practice Act 2004, to empower registration boards to issue guidelines about acceptable PII arrangements and require PII as a condition of registration and renewal of registration.*

6. Investigations and discipline

Mandatory reporting of unprofessional conduct

The discussion paper (chapter 13.1) canvassed the possibility of a legislated mandatory requirement for:

- ♦ Registered practitioners to report to the relevant board where they have reason to believe that another practitioner has engaged in sexual misconduct or other forms of unprofessional conduct.
- ♦ Employers to report to the relevant board when they terminate the employment or curtail clinical privileges of a registered practitioner as a result of their professional conduct or competence.

In considering options, the Department has reviewed existing legislative provisions in this area:

- ♦ An employer or a health practitioner may act as a complainant to a registration board, in the same way as any other member of the public, and have a duty to report serious matters.
- ♦ The Medical Practice Act places a mandatory reporting obligation on a medical practitioner who is treating a registered practitioner who is suffering from an illness or condition that impairs their ability to practice and places the public at risk.
- ♦ Registered medical practitioners and nurses are already required under the Victorian Children and Young Persons Act 1989 to report to the Department's Child Protection Unit if they have a reasonable suspicion that a child has been or is being abused.
- ♦ Additional protections in relation to children are being implemented with legislation to require 'Working with Children Checks'.

Stakeholders held mixed views on these proposals. Those in support noted that there would be difficulties in implementation, whilst those who opposed suggested that boards or the Department should develop guidelines for health professionals and employers on reporting sexual misconduct. There was general support for mechanisms to encourage reporting requirements for employers whilst also recognising that there would need to be safeguards to protect the rights of employees against misuse of such powers.

On balance, the Department is of the view that it is not considered desirable that a member of a health profession, rather than any other member of the public, be guilty of an offence if they fail to report a suspicion of sexual misconduct or other unprofessional conduct by a practitioner. In relation to employer reporting of conduct or competence, the Department is of the view that mechanisms to facilitate such reporting should be encouraged but that, in the first instance, this be through non-statutory means.

Definition of unprofessional conduct

Current legislation uses the terms 'unprofessional conduct not of a serious nature' and 'unprofessional conduct of a serious nature' in disciplinary findings. A finding of 'unprofessional conduct *not of a serious nature*' for many complainants downplays the gravity of the matter and the impact on their lives, particularly in instances where a patient has died or sustained permanent disability.

While Boards have requested that the term 'unprofessional conduct not of serious nature' be replaced by 'unprofessional conduct', this does not provide sufficient clarity. The Department's view is that the terminology applied in NSW health practitioner registration Act, 'unsatisfactory professional conduct' and 'professional misconduct' is preferable. Such an approach would also be consistent with the broader goal of promoting national consistency where possible.

Reform proposals

21. *That the terminology 'unsatisfactory conduct' and 'professional misconduct' be adopted to replace the terms 'unprofessional conduct not of a serious nature' and 'unprofessional conduct of a serious nature'.*

Search entry and seizure powers

The discussion paper outlined a whole of government approach to standardising powers in relation to search, entry and seizure (chapter 13.2) with the objective to strike an appropriate balance between the benefits of inspection powers and individuals' rights to privacy, liberty or property.

Under the new *Pharmacy Practice Act 2004*, the power for authorised officers to enter and search pharmacy premises without a warrant has been retained, however, this has been restricted to when premises are open for business. The retention of this power was considered warranted, due to pharmacists' and pharmacy businesses' responsibilities in respect of scheduled medicines. All other health practitioner Acts currently require authorised officers to obtain a search warrant from the Magistrates' Court before entering and searching premises to investigate possible breaches of the Act where there is no consent.

The Department is of the view that, unless whole of government policy supports otherwise, changes to the search and seizure powers in health practitioner legislation is not warranted at this time. However, some limited revision of provisions may be appropriate, to more closely reflect current policy frameworks.

Reform proposals

22. *That the legislation include standard powers for authorised officers to enter and search premises with a warrant.*
23. *That the current powers of the Pharmacy Board to enter and search pharmacy premises without a warrant during business hours be retained.*

Procedures in relation to notifications and investigations

The discussion paper canvassed a range of reforms sought by various boards to streamline and make more effective investigations and complaints management processes (chapter 19). These included powers to:

- ♦ Provide the discretion not investigate a notification, if it considers it does not warrant investigation.
- ♦ Decline to deal with a complaint if the practitioner concerned has ceased to be registered.
- ♦ Clarify the status of electronic registration and issues regarding statutory declarations.
- ♦ Allow a 'health practitioner', rather than a medical practitioner, to conduct a health examination of a practitioner who is suspected of suffering from ill health, and to have the power to require the practitioner to undergo more than one such examination.
- ♦ Clarify provisions regarding the receipt of medical reports in instances where a practitioner fails to nominate someone to receive such a medical report.

The majority of submissions supported clarification regarding electronic registration and discretion in relation to investigating complaints, however the Department notes the need to ensure that any such discretion is balanced against a notifier's right to have a notification appropriately investigated. The majority of submissions also supported amendments to the provisions regarding health examinations, and the Department recognizes the potential benefits of increasing flexibility in this area.

Whilst many of these issues will in part be determined by the nature of any structural reforms introduced through the current Review, it is the Department's view that the current provisions contained within the Pharmacy Practice Act 2004 provide an appropriate template for addressing the issues raised above.

The discussion paper also sought views as to whether there should be statutory powers to:

- ♦ Require the subject of a notification to provide information or attend an investigation meeting with the Board.
- ♦ Empower the Boards not to give notice of a complaint to a practitioner, if that is likely to prejudice an investigation or place the health or safety of a person at risk, or place the complainant or another person at risk of intimidation or harassment.
- ♦ Empower the Boards to take into account conduct that occurred prior to a practitioner becoming registered, when considering matters relating to whether the practitioner is of good character and should continue to be registered.

In relation to each of these matters, stakeholder input was minimal, and on balance, the Department supports the first two reforms, considering them to have the potential to improve both the efficiency and effectiveness of the regulatory scheme. In relation to the last, it is considered that, if there are sufficiently rigorous processes in place at time of registration, any failure of an applicant to declare matters that may subsequently be grounds for de-registration could be captured under current provisions relating to a grant of registration through fraud or misrepresentation. The current definition of unprofessional conduct includes a finding of guilt of an indictable offence, which provides an additional safeguard. Given this, the Department's view is that an express legislative power to consider conduct prior to registration is not required at this time.

Reform proposal

24. *That the provisions in section 41(1)(c) of the Pharmacy Practice Act 2004 be applied to all health professions in relation to the investigation of notifications.*
25. *That reforms to the provisions contained in the Pharmacy Practice Act 2004 be considered to empower boards to:*
 - *Appoint registered practitioners other than medical providers to conduct health examinations where appropriate.*
 - *Have discretion to not provide notice of a complaint to a practitioner, where this is considered to place a person or persons at risk of harassment, intimidation or harm.*

Procedures in relation to disciplinary hearings

As part of the review, various Boards sought legislative amendments to:

- ♦ Require a hearing panel to make a determination following an adverse finding of unprofessional conduct.
- ♦ Clarify whether a board must refer the findings and determinations arising from an informal hearing to a formal hearing if requested to do so by a practitioner.
- ♦ Clarify the basis for granting suppression orders.
- ♦ Allow all panel members to issue summons returnable on the day prior to commencement of hearing.
- ♦ Reordering of sections 93A(3) and (4) of the Medical Practice Act 1994 to prevent potential challenge of the validity of a warrant on technical grounds.

Such amendments were seen to promote efficiency and provide clarity regarding the boundaries of board powers. The small number of responses received on each of these issues were generally supportive of legislative reform, however the Department is of the view that any such reforms would need to be consistent with other legislation, such as provisions in the Evidence Act 1958, as well as existing case law. As such, it would be inappropriate to change the substance of the provisions regarding issue of summons.

In relation to the other items, the Department is of the view that whilst some of the options for structural reform proposed might address some of these issues, there is no need for legislative amendment to specifically address the concerns raised, and the powers contained in the Pharmacy Practice Act 2004 should form the model for all health professions, subject to further advice on technical aspects during drafting.

Reform proposal

26. *That, subject to considering the effect of any structural reforms, the provisions in the Pharmacy Practice Act 2004 be used as the template in relation to pre-hearing conferences, making of determinations, suppression orders, and the issue of summons.*

7. Regulation of professional practice

Regulation of advertising

The discussion paper set out the current powers of boards to regulate advertising by practitioners and noted the variation in powers across boards (chapter 16).

There was general support for the current powers, with some boards calling for breaches to be prima facie 'unprofessional conduct'. There were also concerns regarding advertising by the unregulated health professions. Some respondents called for stronger powers in relation to use of before/after pictures and testimonials. There was general support for a single set of guidelines, providing they did not undermine current controls by conforming to a 'lowest common denominator'.

The Department notes that:

- ♦ Section 10AB of the NSW Public Health Act provide powers to regulate advertising of health services generally, whether or not the services are delivered by a registered practitioner;
- ♦ The Victorian Health Services Commissioner has been requested by the Minister for Health to conduct an inquiry into the provision of health services to cancer patients by a deregistered practitioner. The inquiry will consider, amongst other things, whether the existing controls over advertising of health services are sufficient.

The Department is of the view that the template provisions as reflected in sections 101-103 of the Pharmacy Practice Act 2004 provide sufficient powers for registration boards to regulate advertising by registered practitioners and the corporations that employ them, however, there is scope to revisit the need for powers to regulate advertising of health services by unregistered health practitioners and agencies, in addition to the controls that apply under the Trade Practices Act 1974 and the Fair Trading Act 1999. It is desirable for boards to develop a single set of advertising guidelines that apply to all the registered health professions. Such guidelines should set minimum standards and promote best practice.

Reform proposals

27. *That the Minister request that all registration boards explore the feasibility of developing a single set of advertising guidelines that address advertising by all the registered health professions.*
28. *That any recommendations arising from the Inquiry by the Health Services Commissioner be taken into account during drafting.*

Regulation of risky and intrusive practices

The discussion paper summarised the approach taken in Victoria and other jurisdictions to regulation of potentially risky and intrusive forms of practice, such as skin penetration, prescribing of drugs and use of radiation equipment (chapter 6).

Many stakeholders supported the adoption of a more restrictive regulatory regime for the registered health professions, with scope of practice definitions in legislation and offences for non-registrants practising. However some registration boards and associations recognised the inherent difficulties in maintaining a flexible and responsive workforce where practice restrictions apply.

The Department is of the view that with the exceptions discussed below, there is no evidence to suggest that the public is at risk from failure to restrict the practice of any additional core practices that are restricted in other jurisdictions, such as spinal manipulation or managing labour and undertaking the delivery of a baby.

Regulation of scope of practice for dental providers

The discussion paper canvassed views on whether there was a need to retain in legislation a restriction on who can practice dentistry and offences for unauthorised practice. Submissions generally supported retaining the current model of restrictions on both title and practice. Respondents argued practice restrictions were necessary because of the substantial risks involved in the practice of dentistry due to:

- ♦ The use of both invasive and exposure prone procedures.
- ♦ The use of pharmacological compounds, potentially dangerous chemicals and ionizing radiations.
- ♦ High infection risks.

Concerns were also raised in submissions regarding the activities of 'backyard operators' who, it was argued, are potentially more of a problem in dentistry than in other health professions.

The nature of the practice and the settings in which dental care is delivered (often in private, independent practice) set dental care providers apart from other registered providers. While medical practitioners undertake similar activities without practice restrictions, they are subject to a range of other controls, for

example, via the Health Services (Private Hospitals and Day Procedures Centres) Regulations that do not apply to dental surgeries. As a 1998 review of the legislation¹² noted "...while there are safeguards against a variety of health risks, some of which apply to dentistry exist in other legislation, the coverage and effectiveness of the public protection extended by these legislation depends on complementary institutional arrangements, which are not necessarily available in dentistry' largely because of the high degree of practitioners working in private practices."

Departmental reform proposal

29. *Given the level of risk associated with dental practice, legislated restrictions on who can practise dentistry should be retained. However, further consideration should be given to legislative definition adopted, that is, whether it should be a broad scope of practice definition or limited to those core practices considered most risky and intrusive.*

Regulation of scope of practice for optometrists and orthoptists

The discussion paper set out a proposal from the orthoptic profession to lift a statutory restriction on their practice contained in the Optometrists Registration Act 1996 (chapter 25.1) which restricts the prescribing of glasses by orthoptists only to those patients who have a current referral from an optometrist or an ophthalmologist. The discussion paper also canvassed whether there is a net public benefit in retaining the current restriction on optometry practice that limits who can measure the powers of vision and prescribe optical appliances such as glasses and contact lenses (chapter 6).

A subsequent submission to the Review from the Optometrists Association Australia (Victoria) sought additional legislative restrictions to prevent sale of (non-prescription) cosmetic contact lenses other than by prescription, that is, from a registered optometrist or medical practitioner.

Optometrists are subject to a range of accountability mechanisms and obligations associated with Medicare reimbursement for eye examinations. The nature of the risks associated with the practice of optometry relate to the potential for visual loss associated with poor eye care, resulting in:

- ♦ Inaccurate or inappropriate prescription of spectacles for children during the period of visual system development.
- ♦ Inappropriate contact lens wear and/or associated infection.
- ♦ Failure to detect the early stages of eye disease such as glaucoma, cataract, age-related maculopathy and diabetic retinopathy.

With the exception of optometry groups, most respondents supported extending the scope of practice of orthoptists to prescribe glasses independently, provided that there is adequate training. The Royal Australian and New Zealand College of Ophthalmologists provided qualified support, recommending there be a restriction that limits independent prescribing only to patients who are 10 years of age or over, to ensure appropriate care during the period of visual development.

The Department recognises the cost to the community associated with a lack of timely access to high quality eye care and the importance of maintaining standards of care. There are three options for proceeding:

- ♦ **Option 1:** Maintain the status quo - retain a legislative definition of optometry and offences for unregistered persons practising optometry, along with current restrictions on orthoptists' practice that require a current referral prior to prescribing of glasses.
- ♦ **Option 2:** Amend the legislation to allow an extended scope of practice for orthoptists, to remove the requirement for a current referral for prescribing of glasses and allow independent practice. This could include a restriction to prescribe only for patients over 10 years old.
- ♦ **Option 3:** Amend the legislation to remove the statutory restriction on the practice of optometry.

In relation to cosmetic contact lenses, there was not sufficient evidence presented to the Review to indicate that there would be a net public benefit in restricting prescription of (non-prescription) cosmetic contact lenses to optometrists. The Department will however continue to monitor developments in this area.

Reform proposals

30. *That a policy position on the question of whether the scope of optometry practice should be restricted in legislation be reserved to allow further consultation with stakeholders.*

Regulation of cosmetic surgery

The discussion paper summarised changes to legislation in recent years to strengthen powers to address the risks associated with the practice of cosmetic surgery and canvassed other options for reform (chapter 21).

¹² 1998 Victorian review of *Dentists Act 1972* and *Dental Technicians Act 1972*, Final Paper, p13.

Respondents indicated concerns about the potential for consumers to be ill-informed and misled about the risks and benefits of cosmetic surgery, that advertising that creates an unreasonable expectation of beneficial treatment, inadequate patient screening and lack of informed consent.

The Department is of the view that legislative reforms introduced in 2000-03 have strengthened considerably the controls over the conduct of cosmetic surgery, including strengthened powers for the Medical Practitioners Board to address sub-standard practice through performance assessment and review and strengthened regulations for day procedures centres so that many procedures can no longer be performed in unregulated clinics. The Department believes, however, there is scope for further reform, as outlined below.

Reform proposals:

31. *That the Health Services Act be amended to ensure that the practice of laser eye surgery and other risky and intrusive cosmetic surgery procedures such as complex liposuction are captured under the definition of a 'day procedures centre'.*
32. *That the Health Services (Private Hospitals and Day Procedures Centres) Regulations 2002 be amended to ensure they apply to any premises where such procedures are carried out, whether or not these procedures constitute a 'major activity' of those premises.*
33. *That the health practitioner legislation include powers to require that advertising of certain specified risky and intrusive procedures carry warning labels approved by the Minister.*
34. *That the Medical Practitioners Board be empowered to issue Ministerially approved guidelines about the practice of cosmetic surgery, and that these guidelines require practitioners to:*
 - *Ensure that advertising is not false or misleading and does not encourage an unreasonable expectation of beneficial treatment.*
 - *Provide prospective patients with a cooling off period before undertaking certain specified risky and intrusive procedures and encourage them to undergo counseling prior to consenting to the procedure;*
 - *Providing balanced written information for discussion with patients on the risks associated with any cosmetic procedure;*
 - *Provide an interpreter where necessary and/or the information be provided in the patient's preferred language; and*
 - *that an anaesthetist be available on site for certain specified risky and intrusive procedures.*

Regulation of prescribing of medicines

The discussion paper set out the current legislative framework that regulates the prescribing of medicines by registered practitioners. At present medical practitioners, nurse practitioners, dentists, optometrists and Chinese medicine practitioners have prescribing rights, but the nature and scope of these rights varies (chapter 20).

Views were polarised on whether approval processes for new drugs or lists of drugs should be streamlined, and whether additional professions such as podiatrists should have limited prescribing rights. Medical stakeholders generally opposed any extensions to prescribing rights or streamlining of approval processes for new drugs. Respondents from those professions with prescribing rights (or with aspirations for prescribing rights) supported more streamlined processes for approving lists of drugs.

The Department is of the view that:

- ◆ Extensions to the scope of practice of various professions to include prescribing rights should be supported, where these professions can demonstrate sufficient training and adequate mechanisms to support safe and competent prescribing practices.
- ◆ There is a net public benefit in supporting an expanded scope of practice for suitably trained podiatrists to prescribe from an approved list of drugs, and that legislative changes to support this extension should proceed.
- ◆ There are adequate safeguards in the Nurses Act to ensure accountability and transparency in the way lists of drugs are approved for each category of nurse practitioner, without the need for the categories of nurse practitioner and lists of drugs to be prescribed in regulation.
- ◆ There must be a transparent and accountable system in place for approving the drugs available for prescribing by practitioners from those professions with limited prescribing rights.
- ◆ The system must ensure that the lists of approved drugs or classes of drugs become official and known/available, for example, to those with statutory responsibilities under the Drugs, Poisons and Controlled Substances (DPCS) Act such as pharmacists and wholesalers.
- ◆ Once an initial list or class of drugs has been approved by the Minister (following advice provided by the Poisons Advisory Committee), administrative arrangements for approving changes/additions to the list should be streamlined and responsibility should reside with the respective boards.

Reform proposals

35. *That the legislation make provision to retain limited prescribing rights for optometrists (drugs for the treatment of anterior eye disease), nurse practitioners (various drug formularies depending on category of nurse practitioner) and Chinese medicine practitioners (Schedule 1 herbs).*
36. *That the legislation make provision for limited prescribing rights for podiatrists appropriate to their scope of practice.*
37. *That the legislation make provision for the following in relation to limited prescribing rights:*
 - *A board responsible for overseeing limited prescribing rights for a profession be empowered to endorse suitably qualified practitioners to be authorised under the DPCS Act to prescribe drugs.*
 - *The board be required to have in place a statutory committee with a membership and functions similar to those set out in sections 79(3) and 80(2) of the Nurses Act.*
 - *The Minister have statutory power to receive applications from a board for approval of endorsed practitioners to prescribe a drug, type or class of drugs, including, where relevant, type of preparation and route of administration, and to approve this application for the purposes of authorisation of endorsed practitioners under the DPCS Act.*
 - *The Minister have the power to determine matters to be addressed in an application for approval of prescribing rights, including:*
 - *The scope of the approval sought.*
 - *The consultation undertaken by the board to determine the need for and scope of the limited prescribing rights, including what expertise it has accessed.*
 - *The arrangements the Board has made to ensure that existing and newly endorsed practitioners have adequate skills and knowledge to prescribe the drugs.*
 - *The safeguards in place to ensure safe prescribing, including any clinical practice guidelines, CPD requirements etc.*
 - *The Minister have statutory power to amend, vary or withdraw an approval at any time.*
 - *The DPCS Act be amended to authorise endorsed practitioners to obtain possess, use sell or supply any Schedule 2, 3, or 4 poison as long as it is consistent with the terms of the Ministerial approval and the endorsement granted by the registration board.*
 - *That once the Minister has granted an approval, the registration board be empowered to issue and clinical practice guidelines for endorsed practitioners, and to amend from time to time any associated drug formulary, as long as such changes are within the scope of the approval granted by the Minister and the requirements of the DPCS Act.*

Maintenance of competence & performance assessment

The discussion paper summarised recent changes to the Medical Practice Act to provide additional powers for the board to monitor professional competence and initiate a performance assessment or performance review where necessary (chapter 7).

There was widespread support from respondents for extending the powers of all registration boards to conduct performance assessments and performance reviews to address unsatisfactory professional performance. There was limited support for publication of CPD compliance on board registers. There was general support for board powers to require refresher training and to collect information from practitioners to determine whether to initiate a performance assessment.

The Department is of the view that the model provisions empowering registration boards to address unsatisfactory professional performance (Pharmacy Practice Act 2004) should be extended in new legislation to all the registered health professions. These powers, along with the power to issue guidelines and deal with unprofessional conduct generally, should be sufficient to encourage practitioners to engage in CPD.

Reform proposals

38. *That the Pharmacy Practice Act 2004 provide the template for drafting provisions to empower boards to regulate professional performance for all the registered health professions.*

Regulation of infection control

The discussion paper outlined current regulatory powers in relation to infection control that are split between registration boards, the Department and Local Councils (chapter 9.6).

There was limited support in submissions for any change in the monitoring of infection control. Respondents opposing change did not consider it to be of significant risk, or considered placing requirements in health practitioner legislation as cumbersome. Submissions supporting change indicated that stricter infection control regulation would result in better public safety.

The Department is of the view that responsibility for ensuring good infection control practices and dealing with any breaches by registered health practitioners should continue to reside with the respective registration boards rather than with local government (which deals with infection control for unregistered practitioners undertaking various forms of skin penetration).

The Department's role under the Health Act complements that of the registration boards and local councils, in that it investigates serious breaches of infection control and provides expert advice to boards and local government to assist them in carrying out their respective roles. With the exception of notifiable disease, where the Department receives a complaint that raises infection control concerns about a registered practitioner, this complaint is referred to the relevant registration board. In order to clarify this division of roles and responsibilities, there is a need for legislative provisions that clarify registration boards' responsibility for ensuring registrants comply with the Health (Infectious Diseases) Regulations and practice based infection control guidelines that are prepared jointly by registration boards and issued following approval by the Minister for Health.

Reform proposals

39. *That the legislation clarify that registration boards are responsible for ensuring registrants comply with the requirements of the Health Act and Health (Infectious Diseases) Regulations.*
40. *That registration boards be encouraged to coordinate the development of practice based guidelines that address infection control requirements for registered practitioners.*

Regulation of complementary therapy practice

The discussion paper identified increasing adoption of complementary therapies by registered practitioners, and questioned whether additional legislative controls were required (chapter 15).

There was general consensus from respondents that standards of practice for registrants who incorporate complementary therapies in their practice is best dealt with through guidelines and codes rather than through legislation. The need for greater communication between professions is supported.

The Department is of the view that practice guidelines issued by registration boards are the most flexible and appropriate vehicle for addressing the complexities associated with the integration of complementary therapies into mainstream health care practice, and that legislative protections for registered practitioners are not required.

Reform proposals

41. *That registration boards be encouraged to co-operate in the development of suitable practice guidelines on integration and use of complementary therapies in registrants' practice.*

8. Offences and sanctions

Sanctions available

The discussion paper outlined sanctions currently available to registration boards, some developments in other jurisdictions, and whether additional more flexible sanctions are required (chapter 13.3).

There was general support for an increased range of sanctions, including training and education, counselling, audit and assessment. There was opposition from some boards and professional associations to a role for boards in ordering refunds or restitutive services, pointing to the availability of common law and cautioning against the boards becoming de facto small claims tribunals.

This needs to be considered in the context of options for structural reform to boards provided in chapter 4 of this paper. Depending on the model adopted, the Department is of the view that there may be scope for increased flexibility for boards in the types of sanctions available and at what point in the investigation/disciplinary process these can be applied. In particular the powers to:

- ♦ Issue advice to practitioners following an investigation, where no further disciplinary action is warranted should be clarified.
- ♦ Settle a matter by mutual consent between a practitioner, a complainant at the investigation stage, without proceeding to a formal or informal hearing and impose conditions, limitations or restrictions on a practitioner's registration, by agreement following an informal hearing.

Reform proposals

That, subject to what option is adopted for structural reform to investigation/disciplinary processes:

42. *The legislation provide for board powers to settle a matter by mutual consent between a practitioner, a complainant at the investigations stage, without the need to proceed to a hearing.*
43. *The legislation provide for board powers to impose conditions, limitations or restrictions on a practitioner's registration, by agreement, following an informal hearing..*

Power to issue fines

The discussion paper identified significant variation in board powers to issue fines (chapter 13.3).

There was general support for an increase in the level of fines registration boards can impose. The Department is of the view that the maximum fine that a board can impose should be standard and that the limit of \$10,000 adopted in section 69(2)(f) of the Pharmacy Practice Act is a suitable figure. This would need to be reviewed, however, if proposals relating to the establishment of a separate health professions tribunal are adopted and further advice from Department of Justice would be sought.

Reform proposals

44. *That fines provided in section 69(2)(f) of the Pharmacy Practice Act be adopted as the template.*

Sanctions against deregistered practitioners

The discussion paper discussed practitioners, deregistered due to serious unprofessional conduct, continuing to provide the same or related health services using professional titles that are unregulated (chapter 13.4) and whether practitioners should be required to pay registration fees during a suspension (chapter 19).

There was overwhelming support for prohibiting deregistered practitioners from continuing to practice. Most respondents preferred that restitution/redress be dealt with by the civil courts. There was little support for the paying of fees during a suspension. There was general support for maintenance of a publicly accessible list of practitioners whose registration has been suspended or cancelled.

The Department is of the view that, where a practitioner has been deregistered serious unprofessional conduct, they should be prohibited from providing services of the same or similar kind and that boards should maintain a public list of such practitioners. In relation to claims for compensation against deregistered practitioners, it may be preferable for these to be dealt with via the HSC or civil courts.

Reform proposals

45. *That the legislation include provision for when cancelling or suspending the registration of a practitioner, the ability to make a court enforceable order prohibiting that practitioner from providing services of the same or similar kind using an unregulated title.*
46. *That the legislation include a requirement that registration boards maintain a publicly accessible register of persons whose registration has been suspended or cancelled.*

Power to recover costs of formal hearings

The discussion paper summarised the new powers of the Pharmacy Board to recover from registered practitioners found guilty of unprofessional conduct its costs of a formal hearing (chapter 13.5).

Respondents expressed mixed views on whether registration boards should have this power. Concerns were raised about whether it might prejudice a board toward a finding of guilt, and the impact on trust in the process of peer review. Responses were also mixed on whether the boards should have the power to suspend a practitioner's registration until the order is complied with.

Whilst the need to ensure impartiality is recognised, such powers have been used appropriately by the Pharmacy Board of Victoria over many years. Empowering boards to require a practitioner found to have engaged in serious unprofessional conduct to pay the reasonable costs and expenses of a board in the conduct of the formal hearing will promote efficiency by ensuring that such costs are primarily borne by these practitioners rather than the professions as a whole.

On balance, it is the Department's view that such powers should be established for all registered professions, with sections 69(2)(j) and 69(5) of the Pharmacy Practice Act adopted as the template..

Reform proposals

47. *That sections 69(2)(j) and 69(5) of the Pharmacy Practice Act 2004 be used as the template for drafting provisions that empower a registration board or tribunal to require a practitioner found to have engaged in serious unprofessional conduct to pay the reasonable costs and expenses of the board or tribunal in the conduct of a formal hearing (or equivalent).*

Statutory waiting periods for re-application for registration

The discussion paper outlined a proposal for establishing in statute a waiting period during which a practitioner whose registration has been cancelled cannot reapply for registration (chapter 13.6).

The majority of respondents supported this proposal. It was suggested that boards should determine the term of the waiting period. The Department supports empowering registration boards to specify, following cancellation of a practitioner's registration, a period during which the practitioner cannot apply for re-registration. Section 69(2)(i) of the Pharmacy Practice Act provides a template.

Reform proposals

48. *That the legislation include powers for registration boards to specify a period during which a practitioner whose registration has been cancelled may not re-apply for registration.*

Corporate offences for directing or inciting unprofessional conduct

The discussion paper outlined recent reforms to strengthen powers for the boards and the Department to act against employers who direct or incite a registered practitioner to engage in unprofessional conduct (chapter 17).

There was widespread support for the extension of the template provisions in the Medical Practice Act to legislation that regulates the other registered health professions.

The Department is of the view that the template provisions as reflected in sections 93-100 of the Pharmacy Practice Act 2004 provide a suitable model for application to all the registered health professions. These provisions are broader than those in the Medical Practice Act, in that they are not limited to persons who are employers of registered practitioners.

Reform proposals

49. *That the legislation include provisions making it an offence for a person to direct or incite a registered practitioner to engage in unprofessional conduct, with sections 93-100 of the Pharmacy Practice Act 2004 providing a suitable template.*

9. Board accountability

Relationship between Minister and Boards

The discussion paper outlined various approaches in legislation interstate and internationally to specifying the relationship between the Minister for Health and registration boards (chapter 4.3).

There was widespread support from practitioner respondents for the status quo, that is, an 'arms length' relationship between Minister and registration boards. With a few exceptions, there was strong opposition to a Ministerial power to direct boards, although some dissatisfied complainants supported such an approach. A number of boards called for more face-to-face meetings with the Minister.

The Department is of the view that the registration function should continue to be constituted as a statutory role independent of Government and not subject to Ministerial direction. Whilst from time to time there have been concerns about the way a board has exercised its statutory powers, such concerns have usually been resolved via negotiation between the Department and the board.

Reform proposals

50. *That the legislation retain the current model in which registration authorities are independent statutory authorities required to provide information to the Minister and take notice of the Minister's views, but are not subject to direction by the Minister.*

Peak advisory body on regulation of health professions

The discussion paper identified international trends to establish peak statutory bodies to advise on the regulation of health professions and review and scrutinize the activities of registration boards (chapter 5.3).

There was strong opposition from boards and professional associations to the establishment of a peak statutory body, primarily because it was seen as unnecessary and unduly fettering the power of registration boards. A substantial number of consumers and other non-profession based organisations supported the increased accountability that would flow from such a body.

The Department is of the view that, while there are potential benefits that might flow from the establishment of a peak body to oversee the operation of the health professions regulatory system, in the current environment a range of other reforms proposed may achieve the same objectives. There is also scope to strengthen the role of the Department to facilitate coordination and cooperation between boards, provide policy direction, and scrutinize board policies, guidelines and reports.

Reform proposals

51. *That the Department continue to monitor the operation of the health practitioner regulation system and facilitate coordination and cooperation between registration boards.*

Ministerial approval of codes and guidelines

The discussion paper set out a range of approaches in other jurisdictions to scrutinizing the activities of registration boards, including a Ministerial power to approve codes and guidelines (chapter 4.3).

There was general opposition from the professions to a role for the Minister in approving board issued codes and guidelines. Concerns related to the potential for bureaucratic delay and for the independence of registration boards to be compromised. Consumers, consumer organisations and policy and regulatory bodies, however, supported the proposal.

The Department believes there is a need for a transparent process for setting standards and issuing codes, and for the Government to have the opportunity to influence the content of some codes and guidelines, particularly where:

- ♦ There is overlapping Department and registration board statutory responsibilities (for example infection control, prescribing of drugs and poisons).
- ♦ There is potential for substantial impact on service delivery and the capacity for the workforce to respond to changing demands (for example, codes that delineate the scopes of practice and supervision requirements of division 2 nurses, dental auxiliaries or probationary psychologists).
- ♦ The Government's performance against policy and/or budgetary targets may be impacted, for example advertising restrictions and National Competition Policy.
- ♦ There are broad public interest issues that extend beyond a particular profession.

Reform proposals

52. *That the legislation include a provision requiring registration boards to consult the Minister, the profession and consumer representatives before publishing any codes of practice or guidelines with the exception of any guidelines that require immediate issue in order to address matters of immediate public health and safety.*
53. *That the legislation include a requirement that any Board proposed code that addresses matters of requirements for registration, scope of practice, supervision requirements, advertising or where Government has overlapping statutory responsibilities, be approved by the Minister prior to release and, if the Minister requires, be published in the Government Gazette.*

Crown monitors and Departmental observers

The discussion paper set out a number of approaches interstate and overseas that involve powers for the Minister and/or the Department to appoint or nominate persons to participate in registration board activities (chapters 4.2 and 4.3).

There was widespread opposition from the professions to 'crown monitors' and/or Departmental officers attending board meetings however, consumers, consumer organisations and policy bodies, supported this.

The Department is of the view that there is a range of tools available to the Minister and the Department to resolve difficulties that may arise from time to time with the operation of a board, including the sanction of removal of one or all of the board members. Power to appoint a 'crown monitor' is therefore, considered unnecessary. However, there is a need for closer liaison and dialogue between the Department and boards, particularly since some board decisions can have a significant impact on workforce recruitment, retention and flexibility as well as service access and equity. While the Department considers attendance at some board meetings desirable, it is not considered necessary for this to be specified in legislation.

Reform proposals

54. *That the Department negotiate, as required, with registration boards to attend board meetings.*

Board meetings open to the public

The discussion paper canvassed views on whether board meetings, or parts of board meetings should be open to the public, and if so, how (chapter 13.6).

With some exceptions there was general opposition from registration boards and professional bodies to open board meetings expressing concerns about the impact on board business. Consumers, consumer organisations and health and broader policy and regulatory bodies, however, supported the proposal.

It is acknowledged that there would be difficulties in allow members of the public to attend meetings while at the same time ensuring the handling of confidential matters. While it may not be desirable to mandate via statute a requirement for open meetings, the Department is of the view that registration boards should give consideration to allowing for parts of board meetings to be open to the public.

There appears no reason why minutes of board meetings should not be made publicly available (providing confidential information on practitioners, consumers and institutions is either de-identified or removed).

Reform proposals

55. *That there be a statutory requirement for registration boards to make the minutes of board meetings publicly available (preserving privacy and confidentiality of material where necessary).*
56. *That the Minister request advice from all registration boards on the feasibility of structuring board meeting agendas to allow for at least parts of board meetings to be open to the public.*

10. Administration

Size of registration boards

The discussion paper identified current arrangements in Victoria (7-12 members) and in other jurisdictions (chapter 4.2). Most respondents supported the status quo.

The Department is of the view that there should be flexibility in the size of boards, with variation depending on the size and composition of the profession and the workload of the board. Experience has shown that a 7 member board is too small to allow effective succession planning. There should be arrangements for:

- ♦ The Minister to appoint additional members from time to time should the need arise.
- ♦ Appointing non-board members to hearing panels as required, from a list of persons pre-approved by Governor in Council. Given the machinery nature of this, amendments are being prepared for consideration in the Autumn 2005 Parliamentary session.
- ♦ The Minister to appoint to casual vacancies from a list of pre-approved persons.

In relation to the Nurses Board, the legislative requirements for appointment of nurse members have presented significant challenges to the process and hampered appointment of qualified and experienced applicants. Given that professions and the industries they work in are dynamic, practitioner positions on boards should not be earmarked in legislation for particular groups or sectors within a profession, except where there are multiple professions regulated by a single board (as in dentistry, Chinese medicine and nursing/midwifery). Ensuring appointment of persons with a suitable mix of experience and backgrounds can be dealt with via guidelines and through consultation with stakeholders.

Reform proposals

57. *That the legislation allow for the Minister to appoint between 9 and 12 members to each board, with flexibility for the Minister to increase the number of members as necessary.*
58. *That the legislation retain flexibility for the Minister to recommend for appointment the most suitable and experienced practitioner members to registration boards, without specifying in detail the sectors or work roles such practitioner members must occupy to be eligible for appointment, except where a board that regulates multiple professions.*

Composition of board and appointment of office bearers

The discussion paper discussed the changing context within which registration boards operate and the need to adapt membership accordingly (chapter 4.2).

There was general support from boards and professional associations for retention of the current ratio of practitioner to non-practitioner members. Submissions from consumers and consumer bodies called for increased lay/legal representation, even for a majority of board members to be non-practitioners. There was strong opposition from the professions to a power for the Minister to appoint non-practitioner office bearers.

The Department supports retention of the peer review model of regulation, however, believes that the international trend for increased public input into all aspects of the regulation of health professions (eg. recent changes to the UK General Medical Council, and the UK Health Professions Council) should be adopted in Victoria. In relation to office bearers, the Chinese Medicine Registration Board model has shown that objections to non-practitioner office bearers can be satisfactorily addressed with the appointment of high calibre non-practitioners to leadership roles, and the arrangements are well accepted by that profession. The Department believes that, to ensure the public interest is best served and smooth and effective operation of boards are provided, the Minister should have flexibility in making such appointments.

Reform proposals

59. *That the legislation provide more flexibility for the Minister to appoint up to half a boards' members from persons who are not practitioners of that profession.*
60. *That the legislation include provision for the Minister to have the flexibility to recommend for appointment to office bearing positions any of the members of the board.*

Term of appointment of board members

The discussion paper summarised current arrangements for appointment of board members and identified various arrangements in other jurisdictions (chapter 4.2).

There was strong support for 3 year terms. Some respondents recommending rolling terms to maintain stability and knowledge base, longer terms and limits on the number of terms. There was also widespread support for the extension of member terms beyond the prescribed terms where circumstances required.

The Department is of the view that three-year terms are satisfactory and it is common practice to ensure staggered reappointments to promote continuity of board expertise. There is a need for a more streamlined mechanism for appointment to casual vacancies on boards. The Department opposes a legislated cap on the number of successive terms, believing this would restrict flexibility.

In relation to extension of terms, the Pharmacy Practice Act 2004 makes provision for up to 3 months, with the consent of the Minister, to allow for unusual circumstances. The Department is of the view that this mechanism should be available for all registration boards.

Reform proposals

61. *That three-year terms be retained, with no legislative cap on the number of successive terms for board members.*
62. *That the legislation include provision for the Minister to directly appoint to casual board vacancies from the list of persons pre-approved by Governor in Council.*
63. *That the legislation include a provision that allows a board member whose term has expired to continue to sit on the Board for a period of up to 3 months while the position is being filled or while completing their role on a hearing panel or other statutory committee of the Board.*

Sitting fees

The discussion paper provided detailed information on sitting fees paid to members of all Victorian registration boards, as well as arrangements in place in other jurisdictions (chapter 4.4).

There was widespread dissatisfaction expressed by most boards and many professional associations with the level of sitting fees paid to board and panel members. Issues raised included the inadequacy of sitting fees to cover income forgone due to attendance at board meetings, preparation time and sitting on hearing panels and the disparities between board sitting fees.

Whilst fees for boards are set via a whole of Government policy, the Department is of the view that there is a need to review the current sitting fees paid to board members, with a view to determining the adequacy of current levels of payment, addressing disparities between boards and determining a suitable mechanism for indexation. Given the system is funded by the practitioners it regulates and these costs are, ultimately, passed on to consumers, there is a need to ensure that sitting fees are not excessive and are commensurate with those paid to board members on other similar organisations.

Reform proposals

64. *That a Departmental review of sitting fees be conducted within whole of Government guidelines, with a view to addressing inequities in current payment rates and establishing consistent arrangements for payment across registration boards for the various functions.*
65. *That a suitable mechanism for indexation of sitting fees be established.*

Powers to charge fees for course approval

The discussion paper canvassed views on whether the legislation should provide a specific power for boards to charge a fee for course approval (chapter 19).

The few submissions on this issue were generally supportive of a legislative change to clarify this power, although one professional association felt that this was not required. Given the importance of this function and, as boards are required to be self-funding, the Department is of the view that the legislation should include a specific power in this area.

Reform proposals

66. *That the legislation include a specific power for registration boards to charge a fee for course approval, where this function is carried out by the board.*

Board member training and support

A key finding of the Review was the need to promote greater consistency and transparency in board operations. Additional administrative mechanisms include:

- ♦ Consistent induction training for all new board members, to ensure they have the appropriate skills and understanding of the complexities of board functions and their responsibilities.
- ♦ Strengthened networks to facilitate information sharing between lay members of all boards, as a means of identifying emerging public interest issues and developing consistent approaches.
- ♦ Establishment of a Consumer Advisory Panel to provide formal advice to the Boards and the Minister on protection of the public interest and consumer input into board operations.

Such measures are consistent with reforms proposed in other areas, for example, the recommendations arising from the recent Victorian Public Hospital Governance Reform Panel Report and are also consistent with other reforms proposed in this paper to enhance consumer involvement in the regulatory scheme.

Reform proposals

67. *That the Department work with the Boards to develop a program of induction training for all new board members.*
68. *That the boards establish a Consumer Advisory Panel, initially comprising lay members from all Boards, to provide advice on current and emerging issues impacting on practitioner regulation from a consumer perspective.*

Reporting requirements

The discussion paper identified disparities in the reporting year for various registration boards and canvassed views on whether the reporting year for all registration boards should be changed to coincide with the financial year (chapter 19).

A small number of submissions were received on this issue and there was no consensus.

The Department is of the view that the current disparities in reporting are not conducive to a strategic approach to regulation of the health professions and present challenges for workforce planning and reporting of complaints and other data. There is merit in establishing consistency in terms of the registration year and reporting year, and that this is best aligned with the financial year in order to meet reporting obligations under the Financial Management Act.

The Minister currently has the power to make reasonable requests of registration boards to provide information. If reporting and registration years are aligned for all the registered health professions, this will allow reporting of all complaints data in the form of a single consolidated report. Such a report will improve accountability and allow more effective monitoring of the health system.

Departmental proposals for reform

69. *That the legislation make provision for the registration and reporting years to be aligned with the financial year.*
70. *That the Minister request registration boards to provide, on an annual basis, a single consolidated report of data on complaints/notifications and disciplinary processes.*

11. Conclusion

Stakeholders are encouraged to assess the options and draft proposals in the context of the review objectives, the principles of the legislative framework and the views put forward by submission to the Review.

The structural options presented could be adopted as standalone reforms or in combination. For example, it would be possible to change the model provisions by maintaining the existing Acts or enacting a single piece of legislation. Similarly, it would be possible to create both a separate formal disciplinary process as well as providing enhanced review rights for complainants.

In some instances, adopting one option may reduce the need to implement additional solutions to address other identified issues. For example, a separate investigation function may, through separating current functions and powers, reduce the need for extra merit reviews throughout the disciplinary pathway.

The challenge is thus to achieve the right balance, and ensure that the final 'suite' of reforms effectively addresses the identified issues in a manner that balances the rights of all parties in the system. Taking this into account, stakeholders are encouraged to assess the options in the context of the review objectives, the principles of the legislative framework and the views put forward by submission to the Review.

As outlined, the options and draft proposals provided in this paper will be consulted on in April 2005 through meetings with key stakeholders and forums to present outcomes of the public consultation process and discuss policy recommendations.

As outlined, the proposals for reform in this paper will be the subject of further consultation in April 2005. Meetings and forums will be held with key stakeholders to present outcomes of the public consultation process and discuss proposals.

Appendix One: Review Process

Analysis of Complaints handling, investigation and disciplinary processes

During May-June 2003, all registration boards were requested to provide information on the management of complaints and disciplinary processes. Interviews were conducted with staff and board members from all boards to identify the key features of the complaints handling and disciplinary processes. Some boards provided detailed written information on complaints handling processes, in the form of manuals and policies. The data collected assisted in the preparation of the discussion paper, and also informed the Review team's views on the issues and challenges with the current system.

Discussion paper

A detailed discussion paper was prepared to facilitate informed debate on issues and encourage participation in the Review. Its primary focus was on the registered health professions. However, issues of concern to unregistered or self-regulated health professions were also addressed. The discussion paper addressed the following matters:

- ◆ PART A: The policy and legislative and regulatory framework and arrangements within which this review is being conducted.
- ◆ PART B: Proposals for general reform of the health professions regulatory system.
- ◆ PART C: Proposals for reform to the management of complaints and disciplinary functions.
- ◆ PART D: Proposals for updating specifics of various health practitioner registration Acts.
- ◆ PART E: Profession specific proposals for reform.
- ◆ PART F: Issues with regulation of the unregistered health professions.

Questions throughout the paper were designed to elicit information and opinions from interested persons. In addition, submissions on matters not directly raised in the paper were encouraged. A total of 116 submissions were received.

Consultation with stakeholders

A range of meetings and forums have been held throughout the whole of the project.

Funded projects

In addition the Department has commissioned a number of studies that will inform the final recommendations for reform. They are:

Complainants Study: A study of the experiences of a sample of complainants who have made complaints to one of five registration boards: the Medical Practitioners Board, the Dental Practice Board, the Psychologists Registration Board, the Chiropractors Board and the Nurses Board.

Alternative Dispute Resolution techniques: A study of the role of 'ADR' techniques within registration board complaints management processes.

Self-regulation models: A study of best practice models for self-regulation of the unregistered health occupations, conducted by the Psychotherapy and Counselling Federation of Australia.

Naturopathy and Western herbal medicine: a study of the risks, benefits and regulatory requirements for the professions of naturopathy and Western herbal medicine. The report has been completed and is currently being edited.

Recovered Memory Therapy: A study of the practice of 'recovered memory therapy', also known as 'repressed' or 'false' memory therapy.

Most of these projects have now been completed, with the results to be released over coming months.