National Registration and Accreditation Scheme for The Health Professions

Exposure Draft of "Bill B"

Health Practitioner Regulation National Law 2009

Submission
to the
Australian Health Ministers' Advisory Council
by the
Australian Osteopathic Association

July 2009

Executive Summary

- Subject to the points below, **AOA supports the Bill.**
- The restriction on practice relating to **spinal manipulation must be extended beyond what is now in the Bill,** in the interests of public safety. The exposure draft is a weakening of the existing legislation.
- **Restrictions around working with the jaw or associated structures must be reviewed** to allow continued practice in relations to musculoskeletal manual therapies.
- All statutory instruments of a legislative character **must be subject to Parliamentary disallowance,** as now provided for in the case of regulations.
- Any **decision that is reviewable must also be appealable.**
- Some clarification is needed about the **application of Commonwealth laws.**
- The Bill should provide for **use of "Dr" by osteopaths,** for the sake of national consistency.
- There is a risk that individual National Boards may issue **guidelines on advertising** which may be inconsistent.
- It is assumed that endorsement of registrations in respect of **non prescription Scheduled medicines** is not intended.
- There is **absolutely no need for the appointment of a Public Interest Assessor** and related bureaucracy. Such appointments will be open to political influence.
- The **costs of the scheme should be clarified.**

1. This submission

The Australian Osteopathic Association (AOA) appreciates the thorough process of consultation in relation to the National Registration and Accreditation Scheme ("NRAS"). In particular, we are grateful for the time and effort put into the consultations about "Bill B", held in Canberra on 12 June 2009.

This submission responds to the invitation to make submissions on the Bill.

2. AOA supports the Bill in principle

Subject to some detailed comments set out below, **AOA is pleased to support the Bill,** and to wish it speedy passage through the various legislatures.

In our view, the exposure draft shows clear signs that earlier concerns expressed by various professional groups, including AOA, have been given careful consideration. It is also clear that the Ministerial Council and those advising it have been at pains to accommodate concerns where that has been found possible. This is appreciated, although some issues of concern remain.

The AOA offers the following comments with a view to further improving the Bill.

The following sections deal with these issues:

- Statutory instruments – section 4
- Application of Commonwealth laws – section 6
- Reviews and appeals – section 5
- Practice Protections including Spinal manipulation – section 3
- Restricted titles – section 7
- Advertising guidelines – section 8
- Scheduled medicines – section 9
- State/Territory Boards – section 10
- Public Interest Assessor – section 11
- Cost recovery – section 12.

3. Practice Protections including spinal manipulation

The AOA is very concerned about s. 137 as drafted in the Bill.

The whole purpose of the NRAS is the protection of public health and safety. As now drafted, s. 137 will put people at serious risk. This is because unskilled, untrained and/or inexperienced persons will be permitted, under this law

- to manipulate the spine, other than the cervical spine;
- to manipulate body parts contiguous to, and affecting, the spine;

- to manipulate the spine and other body parts by other than "high velocity" or "low amplitude" (i.e, low velocity and/or high amplitude).

Moreover, s. 137 does not, in terms, require a member of an "appropriate health profession" to have been specifically trained to what we consider is to be a satisfactory level of clinical practice. That is, any registered chiropractor, osteopath or physiotherapist, or any medical practitioner, is taken to have been adequately trained in one of the most delicate and complex manipulative procedures.
The five-year Masters degree in osteopathy, which is a pre-requisite for practising in Australia, devotes considerable theoretical and practical clinical training to these matters. We believe our graduates are far better equipped in this specialist area of musculo-skeletal treatment than, for example a GP or a physiotherapist who may not have received special training and that the legislation ensure that only "appropriately qualified and practised" registered professionals perform spinal manipulation.

Trained practitioners should only be allowed to provide spinal manipulation as they:

- Are able to identify risks, complicating factors and contra-indications to the procedure, through appropriate appraisal of history and examinations;
- subsequently select appropriate treatment methods, customised for each patients specific condition, including a decision to not treat;
- Must obtain informed consent;
- Possess training/knowledge to offer immediate assistance and first aid in the event that the condition deteriorates;
- Are required to participate in ongoing Continuing Professional Development, therefore keeping abreast of best practice; and
- Are required to hold Professional Indemnity Insurance so that, in the event of an injury, a person is able to obtain compensation.

Currently non-registered practitioners do not meet these requirements.

Currently, all states and territories of Australia, with the exception of Victoria and Western Australia, legislatively restrict the practise of spinal manipulation to a subset of registered health professionals (Victoria and WA have a titles protection only). In addition, South Australia currently restricts all forms of manipulation of the body. As the proposed legislation aims to build on the best aspects of State and Territory schemes, rather than the lowest common denominator, and at all times ensuring that public safety is the priority consideration, previously the Osteopathic Registration Boards of Australia suggested that they have a duty of care to strongly recommend that spinal manipulation should be a legislatively restricted practise under the proposed national system.

Further they went on to suggest that spinal manipulation be defined as per the NSW Public Health Act 1991 *"the rapid application of a force (whether by manual or mechanical means) to any part of a person's body that affects a joint or segment of the vertebral column"* (NSW Public Health Act 1991, Part 2A Division 2 Section 10AC).

We are further aware that an independent review as to whether spinal manipulation should be a restricted act was undertaken in 1999-2000 by PriceWaterhouseCoopers on behalf of Queensland Health; and:

- the independent review concluded a risk of harm was associated with thrust manipulation of the spine, and that
- consumer protection benefits could be achieved from defining thrust manipulation of the spine as a core practice and restricting it to being practised by chiropractors, osteopaths, physiotherapists and medical practitioners.

Clearly this indicated that any thrust manipulation of the entire spine, not just the cervical region should be restricted to the practice of chiropractors, osteopaths, physiotherapists and medical practitioners.

We are also aware that a major health Professional Indemnity Insurer with significant experience and data believes that such concerns are well founded on the grounds of the protection of the public. One of the objectives (and arguably the primary objective) of Bill B is "*to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered*" (see section 4(1)(a)). It is arguable that this objective is not met under section 137.

We have been given to understand that those drafting this legislation took specialist clinical and epidemiological advice on the appropriate scope of s. 137. To the best of our knowledge, no osteopath was consulted in the course of this process and, certainly, the AOA was not invited to be involved.

The AOA urges that these provisions be reviewed, in close consultation with the professional groups (including osteopaths), to ensure adequate protection of public health and safety.

Andrew M Briggs, BSc(PT)Hons, PhD, NHMRC Postdoctoral Research Fellow and Physiotherapist and Rachelle Buchbinder, MB BS(Hons), PhD, FRACP, NHMRC Practitioner Fellow in their article in the Medical Journal of Australia highlighted that 80% of Australians experience back pain and 10% have significant disability as a result. Back pain is neither a single chronic disease with a definitive aetiology nor an injury, and it does not cause death. Furthermore, disability due to back pain may be more amenable to prevention, and significant health and financial benefits could be observed quite quickly by improving the application of evidence-based practice. Back pain and back care in Australia is a major industry.

Unless these provisions are tightened up, AOA will not support the present provision in Bill B. It is of grave concern to us that s. 137, as now drafted, will **allow anyone at all,** including persons holding themselves out as health practitioners of one sort or another but outside the scope of Bill B, to practice non-cervical spinal manipulation. Such risks to public health are not acceptable to professional osteopaths.

Research demonstrates that spinal manipulation is incredibly safe when performed by adequately trained and qualified practitioners; however, the following highlight some of the risks involved and injuries that can occur when unskilled and adequately trained professionals undertake spinal manipulation. It is also clear that serious complications can occur from spinal manipulation other than just the cervical region:

Cervical Region
- Vertebrobasilar accidents resulting in stroke and/or death
- Horner's syndrome
- Diaphragmatic paralysis
- Myelopathy
- Cervical intervertebral disc rupture
- Pathological fractures and/or dislocation
- loss of bladder and bowel control
- paralysis and/or weakness
- loss of sexual function

Thoracic Region
- Rib fracture and costochondral separation
- Pleural Injury
- loss of bladder and bowel control
- paralysis
- Pneumothorax
- Aortic and/or renal or artery rupture
- Thoracic inter-vertebral disc rupture
- Pathological fracture and/or dislocation
- loss of sexual function

Lumbar Region
- Lumbar inter-vertebral disc rupture
- Pathological fracture and/or dislocation
- Aortic and/or renal artery rupture
- Cauda equina syndrome
- loss of bladder and bowel control
- paralysis
- loss of sexual function

Miscellaneous Neuro Conditions Reported to have occurred following spinal manipulation:
- Upper brachial plexus paralysis
- Axillary nerve lesion
- Long thoracic nerve lesion
- Spinal accessory neuropathy
- Diaphragmatic paralysis – phrenic nerve at C4 level.
- Femoral neuropathy
- Spinal Haematoma

Reports of neurological complications following spinal manipualtion fall into four major categories;-
1. Cerebrovascular accidents or incidents as a consequence of arterial dissections resulting in specific stroke syndromes.
2. Lumbar disc syndromes including radiculopathy and cauda equina syndrome.

3. Cervical disc syndromes including radiculopathy and myelopathy
4. Miscellaneous and often unexplained post-manipulation symptoms.

Subdivision 2, s. 135 Restricted Dental Acts

The AOA expresses some concerns in regards to the definition of the restricted dental acts in s. 135. Currently through undergraduate and post graduate training of osteopaths and further in the practice of manual techniques, osteopaths will work on the jaw or associated structures as musculoskeletal practitioners.

Clearly the wording of *s.135 (2) (b) correcting the malpositions of [...] or jaw or associated structures*, is of grave concern to osteopaths; who while not using apparatus and/or permanent procedures are using musculoskeletal, manual therapies to assist patients. Such adjustments are aimed at treating the human jaw and its associated structures with the aim of reducing muscle tension, promoting normal mobility and alleviating pain and dysfunction. To put this matter beyond doubt, the Boards submit that a relevant exemption for this practice be included under subsection (1).

The AOA calls on the Ministerial Council to ensure that osteopaths can continue to practice manual therapies in this area.

4. Statutory instruments

AOA has consistently argued that all standards, orders, guidelines or regulations of a legislative character should be disallowable by Parliament – in this case, of the State/Territory jurisdictions. We note from ss. 286 and 287 that a process is proposed for regulations to be disallowed by a majority of Parliaments.

We see no reason why the various standards, orders and guidelines of a legislative character should not also be subject to the same disallowance processes. We are not referring to directions made in individual cases but to the instruments which are to be made by the Ministerial Council as to standards or guidelines.

In the end, the Ministerial Council is a committee of the Crown in right of eight jurisdictions. It exercises executive power, but that power is conferred by Parliamentary process. It is a fundamental principle of our Westminster system that the exercise of executive power must be reviewable by Parliament. It is the Parliament which delegates powers to the executive, but it does not abdicate.

The Commonwealth Legislative Instruments Act makes no distinction between regulations made under an enactment and other statutory instruments, however described. The test is whether the instrument is legislative in character – that is, laying down general principles for application to various individual cases.

It is recommended that **ss. 286-7 should be extended to operate in respect of all instruments of a legislative character.** A check-list of those which should be so regarded is in the box. The list may not be complete.

Statutory instruments which are appear to be of a legislative character and should be disallowable

s.10 –	Policy directions
s.11 –	standards
s.49 –	standards, codes and guidelines, other than those issued by the Ministerial Council
s. 65 –	Accreditation standards
s. 145 –	advertising guidelines

5. Reviews and appeals

We do not see why some decisions which are reviewable under ss. 243-245 may not also be appealed under ss. 246-250.

This issue goes to the heart of individuals' rights, their livelihood and their reputation, and there should be unfettered access to the "responsible tribunal" for aggrieved persons.

6. Application of Commonwealth laws

6.1 Laws affected

AOA has no objection in principle to the adoption of Commonwealth laws as follows:

- under s. 259 – the Privacy Act
- under s. 261 – the FOI Act
- under s. 279 – the Ombudsman Act

We consider, however, that:

- consideration should be given to applying the Commonwealth Archives Act to the NRAS; and
- there should be no capacity for the Ministerial Council to modify the FOI Act (C'wth) in ways that could negate the important reforms now under consideration by the Commonwealth.

The FOI reforms are designed to break down the culture of bureaucratic secrecy and will be as relevant to the NRAS as any other aspect of regulatory design.

6.2 Status of agencies

It is not clear from the draft bill, how the National Health Practitioners Privacy Commissioner (s. 259 (2)) or the National Health Practitioners Ombudsman (s. 279 (2)) come into existence. If the intention is that these agencies, as named, are to be in fact and in law the Commonwealth agencies, the Bill should say so.

It is also unclear whether the relevant Commonwealth laws will need amendment.

6.3 Application of Law to the External Territories

It is likewise unclear how this objective will be met. In some cases, the laws of a jurisdiction are "taken into" the relevant Territory (e.g. Christmas Island and WA). In the case of Norfolk Island, the situation is less clear.

In our view, it is important, in the interests of public health and safety, that persons cannot practice in Australia as a whole, simply by virtue of a loophole in the application of this Law to persons who may be, or become, registered under external Territory laws.

7. Restricted titles

It is noted that provision in sub-Div. 1 of Div 11 – title and practice protections do not deal with use of the prenomial "Doctor".

Osteopaths may use this term in most States and Territories but not others. It is submitted that this Bill should deal with this lack of uniformity by providing that osteopaths, who have completed a five-year Masters degree and are registered under the new Act, may use the "Dr" title in all jurisdictions.

We also note that medical practitioners, dentists and veterinarians may use the Dr prefix if they possess a Bachelor degree. The AOA agrees that safeguards should be in place to prevent holding-out.

8. Advertising guidelines

Section 145 leaves it to each National Board to draw up a guideline for advertising of the services of the relevant profession. It is therefore conceivable that one Board's guideline may conflict in some material particular with another's.

We consider, therefore, that the National Agency should draw up one set of guidelines, perhaps with appendices relating to particular professions.

As things stand, some professions may disagree as to what may amount to "unreasonable expectation of beneficial treatment" or encouragement of "indiscriminate or unnecessary use of regulated health services". Who is to say which osteopathic treatments, or which clinical advice given to our patients are, or may be, unreasonable or unnecessary?

It is not clear to us that s. 51 would operate to secure a unified approach to the making of advertising guidelines by individual Boards.

The case law on s. 52 of the Trade Practices Act, which uses the same words as s. 145 (1) (a), is voluminous. And, right now, there is a case running in the English courts about what chiropractors can or can't say about the scope of their services.

The advertising of therapeutic goods is heavily regulated by the Therapeutic Goods Act, including provision for self- and co-regulation, pre-clearance of advertisements, complaints assessment and a legislative instrument known as the Therapeutic Goods Advertising Code. We consider that the National Agency may find a developing need for similar provisions.

In any case, the proposed guidelines (or, as we would prefer, a single guideline) **must** be one of the legislative instruments that should be required to be disallowable by Parliament.

9. Scheduled medicines

We assume that, under s. 180, it is not intended to endorse registrations in respect of over-the-counter medicines, ie, those classified as S2 or S3.

As well, the position of practitioners authorised in Victoria to obtain or administer S1 substances needs clarification.

10. Boards

State/Territory Boards

We see these provisions as an unnecessary new layer of bureaucracy and trust that there will be no need for such boards in the case of osteopaths; where in some states Board numbers would equal registrant numbers. The fact that these appointments are made by the State Minister leaves them open to the possibility of politically motivated appointments; compliant and/or biased State Boards.

If appointments are made they should be limited in time and not open ended.

National Boards

National Boards are filled via an expression of interest and then appointed by the Minister; however, in Section 47, the period 'to act' or 'terms of appointment' are defined. Previous consultation papers have highlighted some issues regarding appointments and terms; yet the draft bill is unclear on this issue.

The AOA has previously expressed our concern regarding long term or rolling appointments onto the National Board and believe that fixed limited terms and limited numbers of re-appointments are needed.

Further, due to the creation of State allocated seats on the National Board (as defined by the draft Bill); the vast majority of osteopaths have effectively been prevented from nominating for the National Board. Around 80% of all osteopaths are located in Victoria and NSW; with several of the states and territories having less than 30 registered practitioners.

The National Board should be filled with practitioners with experience and skill in regulations, registration and education. The Bill must have flexibility to allow the National Boards in smaller professions to appoint alternatives when no suitably experienced or qualified practitioner is available from smaller jurisdictions.

National Boards and the Agency

The AOA notes that there will be health profession agreements between the National Agency and the national boards in respect of the resources provided to the boards to carry out their functions. However, we are concerned about what will happen when agreements cannot be reached between the National Agency and the boards. In these circumstances the Ministerial Council should give precedence to the position of the board when providing directions on how the dispute is to be resolved under clause 24(2).

11. Public Interest Assessor

The creation of these posts, and their inter-positioning in various disciplinary proceedings

- is unnecessary;
- confuses the proper roles and responsibilities of National Boards;
- adds another layer of bureaucracy and enlarges the size of the bureaucracy created to manage the National Scheme; and
- must add to the costs, which are to be recovered from registrants, of the scheme as a whole.

In AOA's view, the Public Interest Assessors will really come to represent themselves and not some undefined "public" interest. The National Boards, and attendant machinery, are to be required by statute (see, e.g, ss. 30 or 48) to act in the public interest and should be allowed to get on with it without the intervention of other busybodies.

In practice, appointments by the Ministerial Council of Assessors are likely to be open to political influence, which further negates the appearance of impartiality. As well, s. 35 (3) states that the Public Interest Assessor and staff are taken to be staff of the Agency - thus subject to direction by the CEO.

It would be better for the Bill to provide clear administrative law guarantees of peoples' rights, such as disallowability of all legislative instruments, full transparency of decision making and full access to merits and judicial review. These are the true guardians of the public interest.

Further, the office of the PIA will require additional funding and as it is structured to be in the public's best interest – the public purse should pay. The costs of the PIA should be met fully by Government and not from the registration fees of registrants.

12. Cost recovery

We believe that those drafting this legislation should reveal, before it is debated in the various Parliaments, how costs will be determined and how apportioned in fee schedules. The elaboration of the proposed Agency and Board structures since the proposal was first floated, give cause for concerns that bureaucratic empires, and therefore costs, could soon get out of hand.

13. Area of Need

Section 86, Subsection 5 gives the Minister authority to declare an area of need. There is no requirement to consult with the profession, it is imperative that, at the very least, Ministers be required by law to consult with the relevant profession before declaring an area of need.

14. Process for handling future amendments to legislation

The AOA is gravely concerned that future amendments to the Act may only pass through the Queensland Parliament. Further with no requirement for Parliaments in the other jurisdictions to have the opportunity to consider the amendments or consultation with stakeholders.

As a minimum, the legislation should outline the process for the development of and consultation on future amendments to primary and subordinate legislation.

15. Workforce Data Collection

The AOA; again, strongly calls for the collection of workforce data to be optional and any costs associated with infrastructure and/or the collection of such data to be funded by Workforce Australia.

16. Accreditation

The AOA remains concerned that the Ministerial Council will have some broad power to influence accreditation standards for osteopathic education and training. This is because there is not enough clarity or transparency of the Ministerial Council's use of the mechanisms in clauses 10(3)(d) and 10(4).

The AOA also seeks a guarantee that the Australian Osteopathic Council (AOC) will be the external accrediting body for the osteopathic profession, and that it will have an ongoing role, beyond an initial three-year period, as the external accrediting body for osteopathic education and training.

To date, Ministerial Council communiqués have only stated that it is expected the AOC will be the external accrediting body for the osteopathic profession. We are concerned that the Ministerial Council may seek to influence accreditation processes by appointing, and presumably revoking appointments of, external accreditation entities under clause 60.

In a similar vein, given that national boards can establish accreditation committees under clause 62, it would secure the independence of the accreditation process if the national board, and not the Ministerial Council, were fully responsible for ongoing appointments of external accreditation entities.

The AOA also asks that the draft Bill include the definition of *accreditation standard* provided by the existing national accreditation agencies for the health professions.

17. Practitioner Statements on Registration

Section 124 deals with the statement that each applicant must give the National Board when renewing registration. Section 124(d) provides that the statement include:

> *'if the applicant's billing privileges were withdrawn or restricted under the Medicare Australia Act 1973 of the Commonwealth or by a private health insurer during the applicant's preceding period of registration because of the applicant's conduct, professional performance or health, details of the withdrawal or restriction of the privileges'.*

On further advise; we have grave concerns and suggest that the words *"or by a private health insurer"* be removed from Section 124(d). If this primary submission is not accepted, then at the very least, that part of the legislation should not be operative until all private health insurers in Australia agree to abide by a National Code for the investigation of rebates paid to members. There would need to be regulation enacted to give force to the Code and there would need to be sanctions applied to those private health insurers who breached the Code. An ombudsman role should be created for complaints arising from the National Code for private health insurers.

18. Mandatory Reporting

The AOA fully supports the implementation of a mandatory reporting scheme for health professionals; however it must be strongly linked with practitioner care and rehabilitation programs, only then will such programs succeed.

At the forum on 12 June 2009 a participant drew attention to the fact that the requirement to report a practitioner who has practised while intoxicated by alcohol threatens the existing "good Samaritan" laws. In this regard the public expect (and the law protects) that a health professional will render assistance to a person in need in an emergency situation. It was pointed out that in many of those situations the health practitioner may have consumed alcohol but still provided advice/treatment in the capacity of a "good Samaritan". The AOA believes this is a very valid point and submits that the definition of *"reportable conduct"* should be amended to exclude the actions of a good Samaritan as defined in the National Civil Liability Laws. For example, the *Civil Liability Act 2002 (NSW)* defines a good Samaritan to be a person who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured.

Further we are concerned about the need to be satisfied that the relevant conduct puts the public at risk of "*substantial harm*". Such a subjective term will result in differing standards being applied. The same can be said regarding the expression "*accepted professional standards*". In the circumstances we believe the National

Agency will need to publish information sheets/guidelines on what constitutes *"substantial harm"*.

19. Continuing Professional Competence

The AOA strongly recommends that requirements for registrants to demonstrate continuing competence for ongoing registration reflect good practice and research in this area. Continuing professional development (CPD) requirements must include maintenance of a personal continuing competence record that demonstrates the registrant has engaged in self-reflection and identification of learning needs followed by reflection on learning gained through participation in CPD activities. We also ask that such activities must be from a broad and varied range of topics to prevent continual *'rehashing'* of prior learning.

The AOA does not support the introduction of structures to establish revalidation without legislative requirements for stakeholder consultation on any process.

20. Right to sign a Statutory Declaration

Currently Osteopaths can sign a Statutory Declaration in some states or territories but not others. The AOA calls on the Ministerial Council to set a national standard so all registered health practitioners can sign a Statutory Declaration.

21. Second Draft of Bill B for review

There are a number of major difficulties with the draft Bill. Given that there will be significant re-drafting required to correct these major concerns, there are a significant number of drafting errors, and there is no provision for stakeholder input beyond the 17th July 2009 response deadline, a second draft of the proposed Bill B should be made available for review by stakeholders.