SUBMISSION TO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW EXPOSURE DRAFT BILL B

Authorised by

Neil D Hewson

Federal President

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Australian Dental Association Inc.

75 Lithgow St

St Leonards NSW 2065

PO Box 520

St Leonards NSW 1590

Tel: (02) 9906 4412

Fax: (02) 9906 4676

Email: adainc@ada.org.au

Website: www.ada.org.au

SUBMISSION ON THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (BILL B)

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry, and
- to support members of the Association in enhancing their ability to provide safe, high quality professional oral health care.

There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

The ADA has consistently expressed support for the continued regulation of professional conduct and the protection of public health and safety. The ADA has seen the development of this legislation as one that will create a nationally consistent approach to these objectives.

In general terms the ADA feels that the Bill needs to take better account of the unique nature of dental practice and the dental professions being included under the auspices of the DBA. Dentistry is practiced quite differently to the majority of other health professions. It is primarily involved with surgical procedures being carried out in a “local” not institutionalised setting. With that distinction comes the necessity for recognition of this uniqueness in the sphere of dentistry and if that is achieved then the Bill will be much better suited to the practice of dentistry.

General Comments

The Australian Dental Association (ADA) will in this submission, provide a number of recommendations and comments for improvement to the Bill.

The ADA has concerns that often some provisions in the Bill seem to allow previous appropriate clauses to be ignored or to be circumvented in certain circumstances. The provision of these “avoidance” or “escape” provisions are unsatisfactory as it can lead to lowering of standards.

For example, in commentary provided with the Bill, the clear statement has been made that that there is an independence of the accreditation function from governments. This is supported by the ADA but in the Bill, this independence is not actually provided as evidenced by the inclusion of Section 10 (3) (d) and 10(4). There are other instances of this and these are raised in the following submission

Also there is capacity for extra regulation by State and Territory health authorities compounding border differences in practice over and above such matters as drugs and poisons legislation, radiation and other State/Territory health protection agency matters.

Both outcomes are inconsistent with Bill B having the objects of "protection of the public" and achieving true national consistency.

Given there are four professions under "dental" it is essential that very careful consideration be given to the terminology used as the conventions used for other professions cannot always be applied. In this submission corrections have been suggested in various sections, however to ensure the correct outcome is achieved may require further consultations.

COMMENTARY AND RECOMMENDATIONS FOR MODIFICATION TO THE BILL B

The ADA is grateful for the opportunity to provide comment in relation to the exposure draft of Bill B. In providing its comments, this submission will deal with matters in the order in which they appear in Bill B.

PART 1 Preliminary.

Sections 3: Object of Law

The ADA notes that the object of the law is *to protect the public* and the ADA is supportive of that objective. It says that whilst protection of the public is a worthwhile objective, the Bill must also specifically refer to the maintenance and continuation of safety and quality of care delivery through the scheme created. As such the following recommendations are made en bloc for this section

Recommendations:

i. Section 3 be amended by the addition of the words *"from risk of harm"* after the words *"protect the public".*

ii. Section 3(a) be amended by the insertion of the words *"and provide"* after the words *"competent, and maintain"* and subsequently delete "*and"* after *"competent".*

iii. Section 3(b) be amended with the deletion of the words "*to ensure the public is not placed at risk by the students in the course of undertaking the programs of study".*

Section 4: Objectives and Guiding Principles of National Registration and Accreditation Scheme.

The ADA considers Section 4 (1) (e) to be inappropriate.

Section 4(1) (e) as drafted suggests that one of the objects is to actively "facilitate" access to services. It has been the ADA's belief from the comments made in the lead up to the publication of this Draft Bill that the objective of this reform was in fact to reduce the creation of barriers of access to care. This is a very different role to that of the active pursuit of an objective. Certainly the original Inter Governmental Agreement referred to the promotion of access to health services. The utilisation of the word *"facilitate"* seems to suggest an active role; whereas what

the ADA has believed the intention to be is the prevention of creation of barriers to access to care.

Further, the ADA believes it is essential for there to be a continued linkage between the object of the law (S.3) and the description of the guiding principle in Section 4(1) (e). It is necessary to again reintroduce the emphasis on safety and quality or reduction of harm for the public. Use of the words "*in accordance with the public interest*" here when coupled with the facilitation process proposed, is capable of being interpreted as the ability to facilitate access to services by a lowering of standards of care. If this is the intention then the ADA strongly opposes this. If it is not the intention then the section requires amendment to reflect the correct sentiment.

In respect of Section 4(1)(f), the ADA believes that this sub-clause must refer back to the provisions of Section 4(1)(a) to ensure that the "*development*" referred to in Section 4 (1)(f) is at all times consistent with the objectives stated in Section 4(1)(a) and not to be a separate objective.

In respect of Section 4(2)(c), the ADA has noted the words "*only if it is necessary"* in this sub-clause. The ADA does not consider that the inclusion of those words is required as their inclusion connotes some potential for compromise on the formulation of National Registration and Accreditation requirements.

Recommendations:

iv. Section 4(1) (e) be amended to read *"to not create barriers of access to care provided by health practitioners in accordance with the public interest and consistent with the object of the law*".

v. Section 4(1) (f) be amended by the insertion of the following at the commencement of that sub-clause - *"consistent with the objectives as set out in Section 4(1) (a) hereof and with the object of the law as stated in Section 3".*

vi. In respect of Section 4(2) (c), the deletion of the words *"only if it is necessary".*

Section 6: Definitions

A number of the definitions provided in the Bill require refinement to better suit the intention of the legislation. These include:

- **"accreditation standard"**

  The ADA does not consider the definition to be appropriate. While the existing definition describes what a "standard" is, it does not deal with the accreditation function inherent in the term "accreditation standard".

Recommendation:

vii. The ADA feels that a more appropriate wording would be to replace the existing definition with the following:

***accreditation standard**, for a health profession, means a standard used by an accreditation authority to assess whether a program of study for the health profession and the institution that offers the program, provide graduates with the necessary knowledge, skills and professional attributes to practise the profession in Australia safely and effectively both on graduation and throughout their professional careers; and to guide continuous improvement of the program'*

- **"clinical privileges"**

In paragraph (a) of this definition, the words *"clinical area of practice"* are used. This is a term that is likely to be frequently used. It is believed that this term actually requires its own definition, as it is an important concept within the Scheme's regulation processes.

Recommendation:

viii. The ADA suggests the creation of the following further definition:

***"Area of clinical practice for a health profession"** – "means the performance of specific clinical duties and procedures using a collection of necessary knowledge, skills, experience and professional attributes as recognised by the relevant health profession".*

- **"Criminal History"**

The ADA considers the definition of this term to be exceedingly wide as the utilisation of the word "offence" would include minor traffic infringements and the like. The ADA does not believe that to be the intent of the legislation and suggests that the definition be amended to include references only to "indictable offences". By making this amendment the ADA believes it is more in line with the provisions of Section 142(3) (a) dealing with *"relevant events".*

Recommendation:

ix. Paragraph (a) be amended to read:

"every conviction of a person for an indictable offence, in a participating jurisdiction or elsewhere and whether before or after the commencement of this law."

- **Health Profession**

The ADA will specifically comment upon the definition in sub-paragraph (d) as it relates to *"dental".* The ADA would like to point out that the term *"oral health therapist"* is a title that is used within Australia to describe persons that hold a dual qualification both as a dental hygienist and dental therapist. The title "*oral health therapist"* is used in only one jurisdiction in Australia and is therefore not generally applicable. . Further the term is not used internationally and in particular this matter was recently reviewed in New Zealand where it was agreed to not to use this title. Adding yet another profession in such a small area of health and one not currently in wide use is not required and would cause confusion to both the public and professions

Recommendation:

x. The use of "*oral health therapist*" be removed from paragraph (d) of this definition and be confined to use as a title rather *than* as a specific category of profession under "dental".

The definition of "health profession" generally fits within the Bill B for most professions but the ADA would say this is not the case for dentistry. Due to the unique nature of the dental arrangements under the Bill (where multiple professions are being dealt with), the definition of "*health profession"* should be replaced with "*health discipline"* (in dentistry's case this would be "Dentistry") as usually a professional practices a discipline.

What Bill B is seeking to achieve in relation to Dentistry is the administration of a number of dental practitioners, with the members of each profession, other than dentists, performing their own sub set of the dentistry discipline. It follows because of this that the *health practitioner* definition would also need to be changed.

Recommendation:

xi. The definition "*health profession"* title be replaced with "*health discipline"* and in the definition replace "profession" with "discipline".

xii. The definition "*health practitioner"* be amended to "*means an individual who practices all or part of a health discipline".*

xiii. (d) "dental" be replaced with "dentistry." There would necessitate other consequential amendments through the Bill.

PART 2 Ministerial Council

Section 10: Policy directions

Section 10 (3) (d) and (4).

All indications provided in the development of the IGA including the Guide to the Exposure Draft suggested that the function of accreditation would be *"independent of Government"*. This contrasts with the provisions of Section 10(3) (d) which now says that the Ministerial Council may give directions to a National Board relating to *"a particular accreditation standard for a health profession"*. Whilst the power is limited by section 10(4), it is nonetheless a power given to the Ministerial Council that clearly contradicts the intention of there being independence from government in accreditation.

In each of the Submissions prepared by the ADA in this process, it sought the necessity for the independence of the accreditation process from government. The ADA has insisted throughout that the role of developing standards for the registration function and then the accreditation of training and qualifications for relevant health professions as against those standards should be distinct and separate and both should be carried out independently of each other and of government.

As is envisaged in the modelling of the Scheme to date, the role of standards' creation (and thus the determination of the level of qualifications that are to be obtained by the registrant) for a particular health discipline/profession should rest with the National Board. The ADA wishes to again make the point that this function should rest solely with the Board and not be subject to any Ministerial intervention as is now proposed in the Bill. Remembering that maintenance of safety and quality is to be paramount, standards' creation and with it the development of scopes of practice should only logically be determined and implemented by the professionals, with contribution from lay persons, that have the required knowledge and are experienced in the profession for which the standards are being developed.

Ministers should not have the power to dismiss standards created by a National Board. Ministers have no expertise here whereas the health board, comprising experts, clearly does, and as such, the role should be within the sole and unfettered domain of the National Board.

In the event these recommendations are not accepted, the ADA would ask that in the regulations created accompanying this Act, specific provision be made obligating the reporting of all such "directions" in the National Board's Annual report.

Section 10(4) is inappropriate as its operation infers that the level of standards created is able to be potentially lowered in the event there is a shortage in supply of a health profession. Standards are designed to *protect the public* (S.3) and to ensure practitioners are *suitably trained and qualified to practise* (S.4 (1) (a). To allow these objectives to be compromised to fulfil a short term gap in supply puts the safety of the community at risk. It is the function of government to ensure the provision of an adequate supply of suitably trained health professionals. It is not something that Government should be able to perform by provision of less than fully and suitably qualified practitioners. Lowering of standards to achieve a supply of less than suitably trained professionals is not a solution to a problem (as envisaged by the operation of this subsection); it is a recipe for disaster. It cannot be allowed to remain and must be removed.

Whilst not retreating from the position stated, the ADA would concede that in some extraordinary situations there may be a need for directions to be provided by the Ministerial Council necessitating variations to an accreditation standard. Such circumstances though would have to be confined to circumstances sympathetic to those referred to in Section 4 (2) (c) relating to ensuring that *"health services are provided safely and are of appropriate quality*."

The ADA is concerned that except for scrutiny of national regulations as provided for in S.285, the Ministers are not accountable to any Parliament for the decisions they take, and no appeal mechanism is currently available against a decision that is judged to be inappropriate. As public health and safety issues are ultimately at stake the ADA urges inclusion of such a review mechanism.

Recommendations:

xiv. Deletion of Section 10(3)(d) and 10(4).

Alternatively Section 10 (4) be amended to limit the opportunity for the Ministerial Council to provide such directions by deletion of the words:

"will have a significant and negative impact on the recruitment or supply of health practitioners to the workforce"
and its replacement with:
"will have a significant and negative impact upon ensuring health services are provided safely and are of appropriate quality."

xv. The creation of a proper review process for decisions made by the Council relating to regulations for a profession.

PART 4 Australian Health Practitioner Regulation Agency.

Section 35. Public Interest Assessor.

The creation of the office of the "Public Interest Assessor" is an initiative created under this Bill. It has been indicated that the cost of this new scheme is to be borne by the professions. The ADA objects to the creation of this new office and particularly on this basis. If this office is to be created then it should be at the cost of the Government concerned and not the profession.

Comments made at recent consultation meetings indicate that this office may not be adopted in all jurisdictions. As such, the cost of this office must be met by Government not the professions.

If it is to go ahead, the ADA also calls for the need for there to be a formal reporting process created for this Office. As the legislation is currently framed there is no reporting process in place for this office and it is therefore lacking transparency and accountability.

Recommendation:

xvi. Division 4 (Sections 35-38):

- That the Public Interest Assessor not be established
- Alternatively, specific provision that the cost of the office of the Public Interest Assessor if it is to be established be not borne by the health profession but be separately and independently funded by Government.
- The creation of a reporting process for this office so that its determinations are transparent and accountable.

PART 5 National Boards.

Section 45 Membership of the National Boards.

Consistent with past submissions and requests submitted to the Health Minister, the ADA strongly argues that the further modifications to the Dental Board of Australia (DBA).The DBA's membership was the focus of specific mention in the *Application Guide for the National Boards for Health Professions*. Our comments below are based on the information provided there. See: http://www.nhwt.gov.au/natreg-exp.asp and extract footnoted below. [i]

Dentistry and the creation of a DBA require special consideration. The DBA is attempting to represent a sphere of health practice (four dental health professions) as distinct from a single profession - as is the case for most of the other National Boards that are being created.

As such, the DBA should be extended to include at least two additional dentists to ensure that the DBA can suitably carry out its functions including determining standards for all of dentistry.

The dentist is the team leader in the practice of dentistry and is the only practitioner with the knowledge and skills to practice all of dentistry. While dental hygienists, dental therapists and dental prosthetists have appropriate knowledge and skills for their limited areas of practice, these are confined to limited specific areas of dentistry. Such practitioners will be appropriately represented on the DBA. They will be qualified to comment on their sphere of dentistry but they should not be regarded as expert in all aspects of dentistry. Reference is made to the attached diagrammatic representation at the end of this paper – *"Dental Treatment Field and Levels"* which will set out the various spheres that operate in dentistry and help demonstrate the various spheres of practice and expertise held by each of the dental professions covered by the DBA.

The Chairperson of the DBA must be specified as a dentist. Again, the point is made that while the other dental practitioners should be represented, only dentists are trained and practise in all areas of dentistry and have the overall expertise required to regulate all of dentistry. Without this specification, a Chairperson would often have to deal with matters beyond their expertise.

From a practical standpoint, it is noted there are now requirements for expert (practitioner) representation from the various jurisdictions and to have a regional and rural member. For these requirements to be met the membership of the DBA must be increased by at least two extra dentists, to enable, as a minimum, five jurisdictions to be fully represented.

The ADA strongly believes that past experience (as seen at state dental board level) indicates that without implementing these variations, the credibility and effectiveness of the new Board in achieving the objectives of the Scheme i.e. the improvement in the safety and quality of healthcare delivery - will be seriously compromised.

Recommendations:

xvii. The DBA be extended by the addition of at least two extra dentists.

xviii. There be specific provision that, in view of the DBA's role in covering four health professions relating to dentistry, the Chairman of the DBA be a dentist.

xix. Appropriate adjustments be made to the need for more appropriate jurisdictional representation on the DBA.

Section 57. Consultation about registration standards, codes and guidelines.

The terms of Section 57(1) are strongly supported by the ADA as it involves *"wide ranging consultation"* for development of standards, codes and guidelines. It would be improved if some description could be given as to what *"wide ranging consultation"* involves.

The effectiveness of this provision in subsection (1) is then however totally undermined by the inclusion of S.57 (2) which states that a contravention of S.57 (1) will not invalidate the registration standard code or guideline. This is nonsensical.

The section should indicate with certainty what *"wide ranging consultation"* means. The intent here is deserving of merit but its vagueness should be addressed in the regulations under the Act. The COAG Best Practice Regulation-*A Guide for Ministerial Councils and National Standard Setting Bodies – October 2007* should be followed.

Recommendations:

xx. Section 57 (1) be the subject of specific regulation identifying the nature of the "*wide ranging consultation"* required in accordance with the COAG Best practice Regulation-*A Guide for Ministerial Councils and National Standard Setting Bodies – October 2007*.[ii]

xxi. Section 57 (2) be deleted.

PART 6 Accreditation

Section 64. Development of accreditation standards.

Accreditation standards and their creation should be the responsibility of the health discipline/profession concerned. Accordingly, Section 64 should be amended to include recognition of this.

Section 65. Approval of accreditation standards.

The ADA is concerned that Section 65(2) (a) does not obligate a Board to accept the development of an accreditation standard submitted to it by the "*accrediting authority*." The ADA believes that if the role of accreditation setting is to be provided to an expert "*accrediting authority*" then the Board should not only *"approve"* the standard developed but should actively endorse that Standard.

Section 65(2) (b) requires a consequent change to include the use of the word "endorse."

Recommendation:

xxii. Section 64 be amended by the addition of:

> *'(c) An accreditation standard for a health profession may only be endorsed by the National Board established for the health profession if its approval is recommended by the appointed health profession accreditation entity or an accreditation committee established by the health profession National Board.'*

xxiii. Section 65 (2) (a) and (b) should be amended to delete the word "*approve"* (where appearing) and substitute with the word *"endorse*".

Section 74. Period of Registration

The ADA for practical administrative reasons would support the registration year being a financial year rather than a calendar year even though new graduates would initially be only registering for six months.

PART 7 Registration of health professionals

Section 75. Eligibility for specialist registration

It is noted that there is no pre-requisite for *"general dentist registration"* required prior to being registered as a *"specialist dentist".* Historically, all dentists, general and specialist, have been able to practise in all areas of dentistry without any limitation. The ADA is concerned that in allowing for separate specialist registration without prior general dentist registration may enable a specialist dentist to practise in areas outside that specialist's area of specialty while at the same time the DBA will have had no opportunity to evaluate the Specialist's ability to practise outside their area of specialty.

Consistent with the objectives of maintaining safety and quality in the delivery of care, the ADA recommends that in dentistry there be a pre requisite of general dentist registration prior to being eligible for specialist registration. Without this there is the potential for a practitioner to practise in an area for which the specialist registrant has never been tested.

The creation of a Specialist registration category in respect of the Dentistry needs refinement. Again due to the unique way that the four professions are being dealt with under the Bill, specific attention to this issue of specialist registration is required

Recommendation:

xxiv. Section 75(1) be amended by the inclusion of a new sub paragraph (b) (iii) stating:

"in the case of dentistry, eligibility requirements for general registration as a dentist."

Section 85. Limited registration for area of need.

Section 85 deals with "Limited Registration."

Section 85(5) and 85(6) refer to a *"responsible Minister"* deciding that there is an "*area of need"* based on criteria identified. In the interests of transparency and accountability, the ADA feels that the responsible Minister should in fact be required not only to *"decide"* on an area of need but to publically "declare" an area of need so that the community and profession is alerted to the decision.

Section 85(7) amounts to the granting of an inappropriate delegation of power. The power to delegate in this sensitive area is unlimited in the Bill and needs to be confined to an appointed Minister or other specifically identifiable delegate. It is an important function and should only be carried out by an appropriate identifiable officer of the Crown.

There would be even better safeguards if such declarations were made by the Ministerial Council.

Recommendations:

xxv. Section 85 (5) and (6) be amended to remove the word *"decide"* and it be replaced with *"declare".*

xxvi. Section 85 (7) be deleted or amended to identify a suitably qualified and identified officer of the Crown.

xxvii. Section 85 replace "responsible Minister" with "Ministerial council"

Section 90. Period of limited registration

Recommendation:

xxviii. Section 90 be amended by extending the period of limited registration to 3 years. The ADA can see no practical reason to confine this period to 2 years.

Section 103 (2) Failure to decide application

This provision enables the National Board to not actively decide upon an application for registration. It says the consequence of such inaction will be deemed to constitute a *"decision to refuse to register the applicant."* The ADA can appreciate the thinking that would provide an applicant with a remedy in a situation where a Board failed to act but to enact an ability for a Board to do nothing in any situation is inappropriate.

The ADA suggests that this subsection be replaced and a clause inserted that not only requires the Board to act but obligates it to expedite the determination of all applications for registration.

Recommendation:

xxix. Section 103 (2) be deleted and replaced with a provision directing the Board to actively expedite the determination of any application for registration.

xxx. Section 102 be amended to provide that, in the case of a decision for registration not being made by the National Board within 90 days of lodgement of the application, the applicant be afforded the remedies set out in this section.

Section 124 Annual Statement

Section 124

As the Annual statement requires current information regarding a practitioner, the annual statement requirements should also apply to those with "Limited" and "Provisional registration".

While these practitioners do not require annual renewal, they should still be required to disclose the information in the Annual Statement.

Recommendations:

xxxi. For Section 124 all the current clauses numbered (1)

xxxii. A new Section 124 (2) be added with the following wording "Health practitioners who have limited or provisional registration must in accordance with the annual renewal cycle provide an Annual Statement as specified in Section 124 (1) above.

Section 124 (c) and (d). Annual statement. Also (Section 142(3))

Section 124(c) requires the inclusion of some indication of the criteria that are to be considered by the *"hospital or other facility"* in making decisions on the *"clinical privileges" that* may be *"withdrawn or restricted by the hospital or other facility".*

Without provision of some clear indicative criteria as to what will be the nature of the *"applicant's conduct, professional performance or health*" that will be sufficient to impact on the provision of *"clinical privileges*," the practitioner could potentially be exposed to questionable conduct by the "hospital or other facility" that will affect the practitioner's livelihood. The conduct of the hospital or other entity may be purely commercially driven (albeit based on a broad definition of "performance"), and have no relevance to clinical skills or ability to practise. This is inappropriate.

The ADA strongly rejects that part of Section 124(d) and Section 142(3) that confers any power on a private health insurer (PHI) when dealing with registration. PHIs are not regulated by as robust a process as is in place under Medicare. A decision by a PHI to "derecognise" a practitioner, thereby impacting on a PHI's requirements to pay rebates for treatment received from the practitioner, can be made arbitrarily without affording the practitioner the opportunity to respond to allegations before any final decision is made. This denies the practitioner a right of procedural fairness. Each PHI has its own policy and criteria on which the decision can be based to derecognise a practitioner.

This provision is opposed on two grounds:

a) The section refers to an "*applicant's billing privileges*". It is not clear what is intended by this when dealing with PHIs. The ADA is unaware of any "billing privileges" that exist directly between dentists and PHIs that could be either "withdrawn or restricted". All billing to patients by dentists occurs in the customary commercial way; the dentist directly bills the patient for services. Any arrangement the patient has with the health fund is a relationship independent of the dentist / patient relationship.

   It is acknowledged that from time to time PHIs seek to impose limitations on patients accessing their dentist of choice by limiting rebates payable for services by some dentists to their patients. Such decisions are often quite independent of any consultation between dentist and PHI and can be undertaken at the whim of the PHI without regard to "due process' or "natural justice."

   Such decisions should have absolutely no bearing on any registration process.

b) The proposed section enables PHIs to make determinations on "billing" relating to the *"applicant's conduct, professional performance or health or restriction of the privileges".* This is a totally inappropriate provision of power to PHIs. They would have no specific skills or ability to gauge an applicant's performance under these criteria. PHIs operate for commercial benefit and their decisions on how their members will deal with professionals vis-a-vis dental treatment are often made on commercial (sometimes dubious) grounds. Such decisions based on these grounds have no place in determining the suitability of health practitioners' "*conduct, professional performance or health."*

Recommendation:

xxxiii. Section 124(c) be expanded to provide a list of factors or criteria that can form the basis of a "hospital or other facility" making decisions about "clinical privileges" to be provided to a practitioner.

xxxiv. Any provision granting power to PHIs that would enable a PHI to determine the suitability of a Health practitioner's fitness to practice must be deleted. Section 124(d) therefore needs to be amended to delete any conferring of such powers upon a PHI.

- Section 125(4) may have typographical error where it refers to "subsection (1) (c)". Perhaps this should read (3)(c).

Section 129 Restriction on use of title.

The ADA suggests that while the titles associated with "Dental" are generally appropriate, to avoid confusion and potential dangers from occurring due to the multiple professions being covered under "Dental", the ADA suggests:

- Reservation of the titles "dental practitioner" and "dental surgeon" for use by dentists. The use of these terms has over a long period of time been customarily solely related and confined to use by dentists. The use of the term "dental practitioner" has been the custom in much the same way as "medical practitioner" has been used by medical practitioners. "Dental surgeon" has been synonymous with "dentist" and should therefore be similarly reserved. Reservations of these titles for "dentists" will not create any confusion in use by the other dental professions listed as they have not been adopted by those professions. All the currently recognised specialist dentist titles should also be protected. In the same way the term "the dental profession' should remain as referring to dentists only.

- The term "denturist" should be reserved for use by "dental prosthetists". This title will, as raised in earlier submissions by us, assist the public in identifying more clearly with whom they are dealing when utilising the services if a dental prosthetist. The ADA believes that dental prosthetists would support this additional protection. The title dental prosthetist is often confused with the specialist dentist title of "Prosthodontist."

- The term "oral health therapist" has been commented upon when dealing with the definition of "health profession" earlier in this submission. This title should be reserved as stipulated and should be confined to those practitioners that hold the dual qualification of dental hygienist and dental therapist.

- "Oral care provider" should also be protected as a general term for all the registered dental professionals. The protection of this title would prevent its use by some unregistered persons who conduct activities such as tooth whitening for the general public. The ADA is seriously concerned with the proliferation of such activities by unregistered persons, whose treatment can cause long term harm to teeth, if allowed to be performed by inexperienced hands.

Recommendation:

xxxv. The titles "dental practitioner," "dental surgeon," "denturist," "oral health therapist," and "Oral care provider" and the current specialist dental titles be restricted as outlined above for each.

Section 133 Restriction on use of specialist titles

The ADA supports the more appropriate title "specialist dentist" given that there are only dentists specialise.

Recommendation:

xxxvi. In Section 133(1) (a) (i) replace "dental specialist" with "specialist dentist" and in (ii) replace "person" with "dentist" and "the dental profession" with dentistry

Section 135. Restricted dental acts.

This section is another one where later clauses have the ability to override the initial appropriate clauses

It is noted that Section 135(1) (c) refers to the services of a "*dental technician.*" Nowhere in the legislation is that term defined. Persons performing that work are not registered health professionals, so it is difficult to see how the legislation will be able to interact or deal with dental technicians and that dental technicians will have the need to carry out any restrictive dental act.

Section 135(d) undermines clauses (a) and (b) and so may lead to unintended deregulation of many health services, or increased regulation by State and Territory health authorities compounding border differences in practice over and above such matters as drugs and poisons legislation, radiation and other State/Territory health protection agency matters.

With Bill B having the object of "protection of the public", care will have to be taken to ensure that this object and that a true national consistency is achieved.

In relation to the definition of "*restricted dental act"* in Section 135(2)(a), the ADA does not consider the definition to be adequate. The definition focuses upon "*permanent procedures"*.

The ADA agrees that "permanent" procedures need to be included but says the definition could be improved with the use of alternate words *"invasive and/or irreversible procedures"* instead of "permanent." This would cover a wider and more accurate range of procedures that should be included.

Recommendations:

xxxvii. Section 135(1)(c) be deleted.

xxxviii. Section 135(1)(d) be deleted Care be taken in the future that every effort be made to maintain a national consistency be created when determining conduct that falls within this classification and that regulation development maintain a focus on patient protection and safety.

xxxix. Section 135(2)(a) be amended by the deletion of the words *"permanent procedure"* and replace those words with *"invasive or irreversible procedures*."

Section 142 (3) (c). Information about offences.

Reference is made to the points raised under Section 124 previously.

PART 8 Complaints, performance, health and conduct.

Section 156. Mandatory reporting.

The ADA is generally supportive of what it sees as the objectives of this section. However, Section 156 is in the ADA's view too widely written and its application restricted. For example, as written, it may preclude organisations such as professional associations undertaking and providing valuable assistance in the resolution of many complaints made by the public against health professionals. Often members of the public contact professional associations and raise issues of concern on a range of topics relating to treatment received. Such matters are regularly adjudicated or arbitrated upon to the satisfaction of all parties. The current wording of Section 156 may make it mandatory for the person (if they are a health practitioner) dealing with that matter to report on the issue. Persons fulfilling this valuable role for both the public and profession need to be excluded from the obligation to report on the conduct.

Recommendation:

xl. Section 156(4), which provides the circumstances where mandatory reporting is not necessary, be amended. In subsection (4)(a)(i), the words "*is an employee, agent or nominee*" replace "*is employed by an insurer*".

xli. Further amendment by the inclusion of:

(d) the first health practitioner forms the belief the second health practitioner has behaved in a way that constitutes reportable conduct as a result of a disclosure made by a person to the first health practitioner in the course of providing advice or assistance for the purposes of the second practitioner notifying an incident that may be or will be subject to a professional indemnity insurance claim.

(e) the first health practitioner is a safety and quality assurer and forms the belief the second health practitioner has behaved in a way that constitutes reportable conduct as a result of a disclosure made by a person to the first health practitioner in the course of quality assurance or accreditation of a hospital, community or office based health setting.

Division 4 Dealing with Complaints.

Section 161. National boards may deal with complaints about the same person together

This area of the Bill is cause for concern as it repeatedly refers to complaints being dealt with by the Board or Assessors "en bloc". No doubt the rationale for this is that this would be expedient in complaints' handling. The ADA believes this to be inappropriate.

For example, in Section 161 the National Board is empowered to deal with more than one complaint *"together"* with others. It is felt that if this were to occur, the National Board would

be tainted in its view of the practitioner. Details of all complaints, relating to separate incidents, unrelated conduct or practice matters would be irrelevant to the matter at hand.

Recommendation:

xlii. Section 161 be amended by deletion of the ability to hear unrelated complaints *"together"* and introduce a limitation that complaints can only be considered "together" if the "*complaints are arising out of the same course or type of treatment or arise from the same complainant*."

Section 163(c). National Boards may require further information

This section confers too wide a power in the National Board to investigate complaints by directing inquiries to members of the public.

For reasons similar to those raised in the previous Section 161 commentary, to allow the Board to *"ask (for information from) any other person who has used health services provided by the registered health professional or student*" could severely prejudice the patient/ professional relationship that has been developed. Any member of the public approached for information in these circumstances would instantly have a suspicion aroused as to the suitability of the practitioner.

As any inquiries made would only be sought at a preliminary stage in any complaint process; such conduct will be highly prejudicial to the practitioner. Until there is sufficient evidence as to the establishment of a prime facie case to answer by the practitioner, the valuable confidentiality of patient/practitioner cannot be breached and there must be no contact with a member of the public about a practitioner on the sole ground that the practitioner has treated the *"person that has used health services provided by the registered health practitioner".*

Recommendation:

xliii. Section 163 (c) be deleted or amended to seriously confine the opportunity to approach a patient if grounds already exist establishing a prime facie case to answer by the practitioner.

Section 164(2) (b) Preliminary assessment

Similar concerns are raised here as were raised in respect of Section 161. This subsection allows the potential for the National Board to become biased against a practitioner purely on the basis of the number of complaints received. The section does not qualify the nature of the complaints that can be looked at. Theoretically, the Board may look at complaints that were either disproved or complaints where no adverse finding was made. Doing this would inevitably flavour the opinion of the National Board in relation to the practitioner when in essence, there may never have been any adverse finding made against the practitioner. Human nature is such that persons viewing such material or being alerted to it, would develop a "where there is smoke there is fire 'opinion of the practitioner.

Recommendation:

xliv. Section 164 (2) (b) be deleted.

Section 167 (2). Rejection of complaint

The ADA repeats the concerns expressed at S.161 and 164(2)(b) regarding the ability of the Board to revisit complaints at a later date in the event a later complaint is made. Such a power is contrary to how the legal system operates everywhere else. However this does not mean previous adverse findings cannot be taken into account once a compliant has been proven.

Recommendation:

xlv. The deletion of S. 167 (2).

Section 168. Immediate suspension or imposition of condition

The ADA is concerned that the use of the words *"reasonably believes"* in the introduction of the Section is too low a standard of belief when the consequences of holding that belief will enable *"immediate action"* to be taken that could include suspension or surrender of the practitioner's right to practice without any formal approach having been made to the practitioner.

Immediate action can be taken under the section without hearing from the registrant as to any explanation in relation to any issue. The ability to take such unilateral action without the absolute necessity for allowing the registrant to present any case or explanation must only be exercised if strong, almost irrefutable, evidence of such alleged conduct can be established.

"Immediate action" may have the most serious consequences for the practitioner and the practitioner's patients; yet such action is able to be taken based on a reasonable belief. "*Reasonable belief*" connotes a belief based on the balance of probabilities. This is the civil burden of proof only, yet it is being identified as forming the basis of a belief that will enable a Board to take the most drastic action possible regarding a practitioner's ability to practise. This is inappropriate. The standard of belief must better equate with the severity of the penalty being imposed.

Alternatively, in the interests of commercial and reputation fairness, any immediate action taken based on only reasonable belief not be noted on any public register or made known publically. Any suspension etc. would have to be complied with but not made public knowledge until the establishment of some higher standard of belief.

Recommendations:

xlvi. Section 168(1) be amended to impose a higher level of belief than the current reasonable belief referred to in the Section.

xlvii. Any "immediate action" not be publically recorded on any public register until the conduct or offence is actually proven.

Section 220. Entering places

The term "public place" is used in many Acts of Parliament and is given slightly different meanings in each[iii]. This term should be defined in this legislation so that persons can identify when the powers permitted to be exercised under S. 220 can be imposed.

Recommendation:

xlviii. Create a statutory definition of the term "public place".

PART 10 Information and privacy.

Section 266. National Boards to publish certain decisions.

This section imposes an obligation on the National Board to publish all findings in relation to practitioners. The ADA contends that such publication should only be required when an adverse finding has been made in respect of a practitioner; where publication on safety grounds is required; where an adverse finding has been reversed or the penalty period expired.

There should be no obligation to publish favourable findings in any matter unless the investigation of the complaint concerned has itself been made public. There is no point in alerting the public that Practitioner X has no case to answer or succeeded in defending a case of improper practice or the like if the public were not otherwise aware of the matter.

Recommendation:

xlix. The obligation to report findings by the National Board be confined to cases or instances where the public's awareness of a matter is required for their safety or where it refers to a practitioner's ability to resume practice following the publication of an earlier adverse finding against the practitioner. There should be no need for the publication of findings made in favour of a registrant unless earlier unfavourable findings have been publically recorded.

- Section 266 (1) (c) makes no sense and the wording needs to be revised.

PART 11 Miscellaneous.

Section 280. Protection from personal liability for persons exercising functions.

The ADA accepts the need for protection to be afforded to the "*protected persons*" identified in subsection (3) but feels that protection should also be extended in appropriate cases as is provided in "whistleblower" protection legislation. I.e. in areas of public interest.

Recommendation:

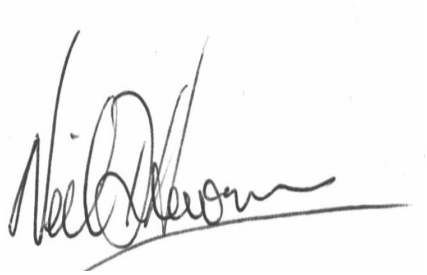
L. Either the definition of "protected person" be extended to include "whistleblowers" or a new subsection (4) be added to afford "whistleblowers" the appropriate protection made available to them in other legislation.

Conclusion.

As indicated in the introduction to this submission, the ADA has supported the continued regulation of professional conduct and the protection of public health and safety. The ADA has seen the development of this legislation as one that will create a nationally consistent approach to these objectives.

The ADA believes that despite the extensive consultation processes undertaken to date, this legislation is still in need of significant amendment before it will function as an effective instrument to ensure that the initial objects of the IGA are met.

The ADA remains prepared to work closely with governments to assist them to establish a model that best fits the model of registration and accreditation created for the dental profession.



Dr N D Hewson
Federal President
Australian Dental Association Inc.

[i] "Practitioner member requirements specific to the Dental Board of Australia
Practitioner members of the Dental Board will comprise three dentists, one dental therapist, one dental hygienist and one dental prosthetist."

[ii] See in particular Principle 7 and Schedule F thereof. The Office of Best Practice Regulation (OPBR) states that a public interest test should be used where a regulatory proposal is likely to have a significant impact on stakeholders:

> *"The Government requires that [Regulatory Impact Statements] include a comprehensive assessment of the expected impact (costs and benefits) of each feasible option. The objective should be to choose the most appropriate option for resolving the identified problem and to provide readily accessible evidence to support this decision. The overall expectation is that the* ***benefits to the community*** *of the recommended option exceed its costs and have the greatest net benefits (benefits minus costs) to the community of all alternative approaches considered."*
> (Source: Office of Best Practice Regulation Handbook, August 2007, p 68. Emphasis added)

[iii] See for example: Tennant Creek (Control of Public Places) by-laws - sect 2 and Summary Offences Act 1988- NSW.Section 3 definitions.

Dental Treatment Fields and Levels

* General practitioner dentists are trained to diagnose and provide treatment <u>across all fields</u>, and to a quite complex level.
* Dental specialists do advanced training to deal with extremely complex work within a narrow field.
* Ancillary dental providers are trained to do basic diagnosis and provide basic treatment in only some aspects of dentistry.