



Health

***Health Practitioner Regulation
National Law (NSW)***

STATUTORY REVIEW

DISCUSSION PAPER

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1. Introduction

Prior to 1 July 2010, there were differences across the States and Territories regarding the registration of health professionals and the accreditation scheme for health education and training. In NSW there were 12 separate health professional registration Boards in NSW. Those 12 Boards registered 17 separate professional groups (some of which, being dental technicians and optical dispensers, are no longer registered). Three of the 12 Boards, the Dental Board, the Medical Board and the Pharmacy Board, operated independently whilst the other 9 were clustered together under the umbrella of the Health Professional Registration Boards (HPRB), a unit of the Health Administration Corporation¹.

On 14 July 2006, and following a Productivity Commission Report, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals. COAG further agreed to establish a single national accreditation scheme for health education and training, in order to simplify and improve the consistency of current arrangements.

Thus began the intense national negotiations to establish the National Registration and Accreditation Scheme (NRAS) across Australia. The NRAS is established in the Schedule to the Health Practitioner Regulation National Law Act 2009 of Queensland. All States and Territories have adopted² the Queensland Schedule, subject to various amendments, as their own law which ensures a nationally consistent scheme across Australia in relation to registration and accreditation.

While the NRAS operates as a national registration and accreditation scheme, the scheme was established to allow jurisdictions to decide whether to adopt the national provisions relating to conduct, health and performance and complaints handling. If a jurisdiction decided not to adopt the national provisions relating to conduct, health and performance and complaints handling, they would become a “co-regulatory” jurisdiction. NSW is a “co-regulatory” jurisdiction.

Accordingly, the establishment of NRAS in NSW consisted of:

- the Health Practitioner Regulation Bill 2009 passing Parliament in November and receiving the Governor’s Assent on 19 November 2009 to become the Health Practitioner Regulation Act 2009. The Act adopted as a law of NSW the Schedule to the Health Practitioner Regulation National Law (Qld)³, as updated from time to time;
- the Health Practitioner Regulation Amendment Bill passed Parliament on 8 June 2010. The Bill received the Governor’s Assent on 15 June 2010 and the Health

¹ With the advent of National Registration, all previous Boards were replaced by Health Professional Councils with the Health Professional Council Authority (HPCA) providing administrative support. The HPCA is an executive agency of the Ministry of Health.

² Except Western Australia. Western Australia passed legislation to mirror the Queensland Schedule. See Health Practitioner Regulation National Law Act (WA) 2010

³ Other than Divisions 3–12 of Part 8 (which relate to complaints handling): see s6 of the Adoption Act

Practitioner Regulation Act 2009 became the Health Practitioner Regulation (Adoption of National Law) Act 2009 (Adoption Act). As a co-regulatory jurisdiction, the 2010 amendments amended the Queensland Schedule as it operates in NSW to introduce the unique NSW Part 8 (Health Performance and Conduct) and Part 5A. At the time, NSW was the only co-regulatory jurisdiction in Australia and the NSW Part 8 set NSW on a different path to dealing with complaints about practitioners than the rest of the country⁴. NSW retained the independent Health Care Complaints Commission (HCCC) and the dual roles of the HCCC and the NSW health professional Boards (which were renamed “Councils”) in dealing with complaints as this model of complaints handling was seen as the most appropriate method of handling complaints in NSW⁵.

NRAS operated across Australia with 10 professions from 1 July 2010 to 30 June 2012. However, on 1 July 2012, four new professions were introduced into the National Scheme on, Chinese medicine, Aboriginal and Torres Strait Islander health practice, medial radiation practice and occupational therapy.

As it has been 5 years since the passage of the Adoption Act, it is now time to review the operation of the law.

1.1 Review of the Health Practitioner Regulation National Law (NSW)

Section 9 of the Adoption Act states:

- (1) The Minister is to review this Act to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.*
- (2) The review is to be undertaken as soon as possible after the period of 5 years from the date of assent to this Act.*
- (3) A report on the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the period of 5 years.*

In accordance with s9 of the Adoption Act, a review must be held to determine whether the policy objectives of the Health Practitioner Regulation National Law (NSW) remain valid and whether the terms of the Health Practitioner Regulation National Law (NSW) remain appropriate for securing those objectives. The review is to commence 5 years after assent of the Act, being 19 November 2014.

⁴ Since 1 July 2014 and the commencement of the Queensland Health Ombudsman Act, Queensland has become a co-regulatory jurisdiction and also has a different complaints handling mechanisms and processes to the rest of the country.

⁵ Further explanation on the reasons why NSW decided to retain its own specific complaints handling model can be found in the then Minister’s second reading speech:
<https://www.parliament.nsw.gov.au/prod/parliament/nswbills.nsf/d2117e6bba4ab3ebca256e68000a0ae2/ba3fca5b8fca4a38ca257727001bc201?OpenDocument>

An independent National Review of the NRAS took place in 2014, under the auspices of the Australian Health Ministers Advisory Council, with a discussion paper being released by the independent reviewer, Mr Kim Snowball. The National Review considered aspects of the NRAS but not the NSW specific provisions relating to complaints handling.

In light of the National Review, the NSW statutory review will focus only on the NSW specific provisions of the Health Practitioner Regulation National Law (NSW), particularly Parts 5A and 8. However, the Ministry will consider findings and recommendations of the National Review. The final report on the National Review is expected to be handed down in the first half of 2015.

In this Discussion Paper, the following terms are used:

- the 'National Law' refers to the nationally consistent provisions of the Schedule of the Health Practitioner Regulation National Law (Qld) and the complaints handling provisions for all jurisdictions other than NSW and Qld⁶, and
- the 'NSW specific provisions' refer to the modifications that have been made to the National Law in NSW (and which primarily relate to the handling of complaints in respect of registered health practitioners),
- the 'Health Practitioner Regulation National Law (NSW)' refers to the law as a whole as it applies in NSW, that is the National Law as modified by the NSW specific provisions,
- 'NRAS' or the 'National Scheme' refers to the national registration and accreditation scheme, and
- the 'National Board jurisdictions' refer to those jurisdictions that utilise the National Board processes for complaints handling under the National Law.

⁶ It is noted that following the commencement of the Health Ombudsman Act 2013 (Qld), Queensland recently became a co-regulatory jurisdiction and has its own provisions relating to complaints handling.

2. Submissions

Comment is invited on issues raised in this Discussion Paper or on any other aspect of the Health Practitioner Regulation National Law (NSW). There is no special form for submissions. Submissions should be in writing and directed to:

Legal & Regulatory Services – Legal Branch
NSW Ministry of Health
Locked Bag No. 961
North Sydney NSW 2059
Email: legalmail@doh.health.nsw.gov.au

This Paper can be found at <http://www.health.nsw.gov.au/legislation/Pages/Acts-under-review.aspx>. The closing date for comment is **7 August 2015**. Inquiries can be made to Legal Branch on (02) 9391 9606.

Individuals and organisations should be aware that generally submissions made on the Review may be made publically available under the Government Information (Public Access) Act 2009. The Ministry of Health, in formulating its Report on the Review, may also circulate submissions for further comment to other interested parties or to publish parts of submissions. If you wish your submission (or any part of it) to remain confidential (subject to the Government Information (Public Access) Act), this should be stated clearly and marked.

3. Issues for consideration

In October 2014 the Ministry wrote to a range of stakeholders to seek preliminary views on matters that should be considered as part of the Review. After considering the submissions received, the Ministry has identified a range of matters that should be considered as part of the Review which are dealt with below. The Ministry will also take and consider submissions on any other issues that are not outlined in the Discussion Paper that relate to the Health Practitioner Regulation National Law (NSW).

3.1 Objectives of the National Law

Section 3 of the Health Practitioner Regulation National Law (NSW) sets out the objectives and guiding principles that apply to the National Law:

- (1) The object of this Law is to establish a national registration and accreditation scheme for—*
 - (a) the regulation of health practitioners; and*
 - (b) the registration of students undertaking—*
 - (i) programs of study that provide a qualification for registration in a health profession; or*
 - (ii) clinical training in a health profession.*
- (2) The objectives of the national registration and accreditation scheme are—*
 - (a) 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; and*
 - (b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and*
 - (c) to facilitate the provision of high quality education and training of health practitioners; and*
 - (d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and*
 - (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and*
 - (f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.*
- (3) The guiding principles of the national registration and accreditation scheme are as follows—*
 - (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;*
 - (b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;*

(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

These objectives are consistent across the National Law as it applies to all States and Territories, including NSW. There is, however, an additional NSW objective. Under amendments made in 2012⁷, the NSW Parliament added another objective in s3A. Section 3A relates to the NSW specific provisions and provides:

In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.

This additional objective is consistent with an objective clause inserted into the Health Care Complaints Act 1993 and the old Medical Practice Act in 2008⁸. Following the amendments in 2012 to include the new s3A, the Ministry's view is that the objectives of the National Law are appropriate and remain valid. However, the Ministry seeks submissions on whether there should be any changes to the objectives of the National Law.

Issues for consideration?

- 1) Are the objectives of the Health Practitioner Regulation National Law (NSW) appropriate?

3.2 Process for amending the Health Practitioner Regulation National Law (NSW)

As noted earlier, the structure adopted to implement NRAS was for the law to be passed by the Queensland Parliament as a Schedule to the Queensland Health Practitioner Regulation National Law Act 2009. Most States and Territories⁹ adopted the Schedule *as updated from time to time*. NSW did the same, making changes to the complaints processes, but otherwise adopting the Schedule in full. The result of the updating provisions is that any future changes made to the Queensland Schedule automatically become law in NSW without reference to the NSW Parliament¹⁰.

Given the intention was to establish a nationally consistent legislation, there are good reasons to apply a law, as updated from time to time, of another State or Territory as a law of NSW. Applying another State's or Territory's law ensures consistency of the legislation across the States and Territories. However, a number of issues can arise in adopting the

⁷ As contained in the Health Legislation Amendment Act 2012

⁸ See s3(2) of the Health Care Complaints Act and s2A of the repealed Medical Practice Act 1992. Both these sections were amended in 2008 by the Medical Practice Amendment Act 2008

⁹ Except for Western Australia and South Australia. Western Australia passed its own law, Health Practitioner Regulation National Law (WA) Act 2010, which mirrored the Queensland Schedule. South Australia adopted the Queensland Schedule as at 1 July 2010: s4 of the Health Practitioner Regulation National Law (South Australia) Act 2010

¹⁰ Other than changes to Part 8 of the Schedule to the Health Practitioner Regulation National Law Act 2009 (Qld), as this Part was not adopted into NSW law. See s6 of the Adoption Act.

Schedule to the Health Practitioner Regulation National Law Act 2009 (Qld), as updated from time to time, as a law of NSW:

- The first relates to issues of State Sovereignty. If changes are made to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) they automatically become law in NSW and there is no Parliamentary oversight of the changes. There is no opportunity for Parliament to debate, amend or reject the changes. It is likely these concerns caused Western Australia to introduce mirror legislation rather than apply the Health Practitioner Regulation National Law Act 2009 (Qld) as a law of Western Australia¹¹. South Australia adopted the Health Practitioner Regulation National Law Act 2009 (Qld) but only at the date of 1 July 2010¹². This means, in South Australia, if any changes are made to the Health Practitioner Regulation National Law Act 2009 (Qld), they do not automatically apply to South Australia but rather South Australia must introduce its own legislation to adopt the changes.
- The second issue relates to flexibility. For changes to be made to the Schedule to the Health Practitioner Regulation National Law Act 2009 (Qld), under the COAG intergovernmental agreement, all States and Territories must agree to the change¹³. However, this can create problems if all States and Territories bar one agree to a change. With NSW being a co-regulatory agreement, this may create problems. For example, if a change was proposed to the registration provisions of the National Law which all other States and Territories supported, but the proposed change could adversely impact the NSW specific complaints handling provisions, then NSW's only options would be to refuse to consent to the changes or agree to the changes and then introduce legislation amending the Health Practitioner Regulation National Law (NSW). However, neither option is without difficulty. The first option may adversely impact other States and Territories. The second option may cause problems in NSW as the changes may have already commenced before the legislation is introduced and passed by the NSW Parliament.

In view of these issues, the Ministry is considering whether there is a need to establish a mechanism under which:

- State Sovereignty, and the specific issues arising in the NSW co-regulatory system, can be respected,
- there is appropriate flexibility, and
- the NRAS scheme operates, to the extent applicable in NSW, as a national scheme.

¹¹ See s4 of the Health Practitioner Regulation National Law (WA) Act 2010

¹² See s4 of the Health Practitioner Regulation National Law (South Australia) Act 2010

¹³ Under the COAG intergovernmental agreement, decisions of the Ministerial Council, including to make legislative amendments, are by consensus:
https://www.coag.gov.au/sites/default/files/iga_health_workforce.pdf

As part of this, the Ministry is considering a number of options, including amending the NSW legislation to require regulations to be made adopting any changes to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) (which such regulations being able to be disallowed by Parliament) or by allowing regulations or a proclamation to be made declaring that changes made to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) do not apply to NSW.

In this regard, it is noted that other legislation in NSW establishing national regimes have mechanisms for not accepting changes made to the national regime, such as under the Competition Policy Reform (New South Wales) Act 1995¹⁴ or the Fair Trading Act 1987.¹⁵

Issues for consideration?

- 2) Should the Health Practitioner Regulation National Law (NSW) have a provision that allows regulations to be made disallowing changes made to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) or that requires regulations to be made in NSW before changes made to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) take effect in NSW?

3.3 Structural and organisational matters: Health Professional Councils

The Health Professional Council Authority (HPCA) is an administrative unit of the Health Administration Corporation, which is the Health Secretary incorporated as a corporation sole. Staff working within the NSW Councils are employed through the HPCA which effectively provides services and support for their operations.

The costs associated with the operation of the HPCA are met by the various Councils whether directly, in the case of expenses that relate to a specific Council, or indirectly, in the case of expenses that apply across the board. All funds (with the exception of a small ad hoc grant to support the operation of the Aboriginal and Torres Strait Islander Health Practice Council) come from the “NSW portion” of registration fees paid by health practitioners. These fees are collected by the Australian Health Practitioner Regulation Agency (AHPRA) and transmitted to the Secretary of Health who holds them on behalf of the Councils.

Under the NSW specific provisions, a Health Professional Council is established for each profession¹⁶. Each of the Health Professional Councils is an independent statutory authority with reporting obligations under the Annual Reports (Statutory Bodies) Act 1984 and the Public Finance and Audit Act 1983.

¹⁴ See s6 of that Act

¹⁵ See s29 of that Act

¹⁶ Section 41B of the National Law

The above structure, while recognising the differing professional groupings, causes complications for both the Councils and the HPCA:

1. Financial

The HPCA as an agency receives no funding from the Ministry of Health¹⁷ or from NSW Treasury. It is reliant on the Councils to meet its operating expenses, including the cost of the staff employed for the Councils. The HPCA is unable to undertake expenditure or projects of any significance without the approval of the Councils. In the case of significant strategic projects that are of benefit across the board, the restrictions imposed by the need to consult with 14 separate Councils can lead to delays or a rejection of the proposal.

It has also become increasingly clear in recent years that the Councils regulating the smaller professions can experience significant financial stress associated with an inability to generate economies of scale due to the smaller number of registrants. While the lack of economies of scale has always existed, the impact has become more severe since July 2010 with more smaller Councils and as increasingly sophisticated methods have been used to accurately allocate costs and eliminate cross-subsidisation; and as more rigorous and sophisticated processes to manage complaints (including performance complaints) and monitor practitioners' compliance with conditions have been implemented across the board. For example, the small number of Aboriginal and Torres Strait Islander practitioners means that the profession is currently subsidised by the Government at both the State and national level.

Financial difficulties can also be created when a Council experiences a higher than expected number of complaints and this is particularly so for the smaller professions who may have less of a reserve to draw upon.

2. Reporting and financial impacts

As Councils are independent statutory authorities each Council is required to produce separate statutory accounts, have those accounts independently audited, and prepare an annual report. A significant amount of expense and effort goes into this reporting. The Councils, and therefore the professions and ultimately the public, meet the costs associated with that reporting. For the smaller Councils, the requirement to produce separate accounts, and have those accounts audited, imposes additional cost burdens that can impact the financial viability of the Council.

¹⁷ Except for a small grant in respect of the Aboriginal and Torres Strait Islander Health Practice Council

Each Council is also required to report on a periodic basis, usually bi-annually or annually, on a range of matters including privacy complaints; Government Information (Public Access) Act applications; Public Interest Disclosure Reports; Digital Security Policy Compliance and EEO functions. For most of the smaller Councils these reports contain either no information or very limited information, due to the limited number of relevant applications or disclosures made.

However, the current structure also delivers a number of benefits:

1. Flexibility

As each Council is independent it can, within the constraints imposed by the legislative scheme, develop its own processes and seek to innovate.

2. Professional ownership

The existence of a separate Council for each profession means that for the most part practitioners are judged by their peers on issues concerning professional standards and behaviours. This tends to lead to a sense of identification with the Councils and that, by and large, the regulatory decisions of the Councils and their committees and panels are more readily embraced and respected by the professions.

Despite the benefits of the existing structure, the financial implications for the smaller Council have the very real potential to create on-going difficulties. Given this, consideration needs to be given as to how to ensure a cost effective scheme that appropriately protects the public.

The National Review also considered the issue about the cost implications for the smaller professions and raised the issue of consolidating the nine smaller, and lower regulatory, professions into one combined national Board. In light of this, it is appropriate for NSW to consider whether some form of consolidation of the Councils is required, which is considered further below.

3.3.1 Consolidation of the lower generating complaints professions into one Council

There are nine professions that have a lower complaints volume, which are set out below:

Council	New Complaints 12/13	New Complaints 13/14	Total Complaints Managed over 12/13 and 13/14 (includes carry over from 2011/12)	Monitoring Cases Managed over 12/13 and 13/14	s150 'Hearings' over 12/13 and 13/14	Referrals to IRPs and PRPs 12/13 and 13/14	Referrals to Inquiries 12/13 and 13/14	Referrals to PSCs and Tribunals 12/13 and 13/14	Other - Assessment Committees Counselling etc over 12/13 and 13/14
ATSI	0	0	0	0	0	0	0	0	0
Chinese Medicine	17	8	25	3	1	0	2	0	3
Chiropractic	22	32	71	8	2	0	0	2	11
Med Radiation Practice	5	13	18	2	0	4	0	0	0
Occupational Therapy	8	9	17	1	1	1	0	0	1
Optometry	12	25	44	2	9	1	0	0	1
Osteopathy	6	6	19	2	0	0	1	3	2
Physiotherapy	30	31	69	6	5	3	0	1	12
Podiatry	12	13	33	3	0	0	0	1	7

The above 9 Councils have over the last 2 years received a total of 249 complaints between them (4% of the total number of complaints received by the HPCA across all professions).

This contrasts with the other 5 Councils which over the same period received 5,936 complaints:

- The Medical Council's 3,457 complaints over 2 years represents 55% of the HPCA total;

- The Nursing and Midwifery Council's, 1049 complaints over 2 years represents 16.7% of the HPCA total;
- The Dental Council's 835 complaints over 2 years represents 13.3% of the HPCA total;
- The Pharmacy Council's 376 complaints over 2 years represents 6% of the HPCA total; and
- The Psychology Council's 318 complaints over 2 years represents 5% of the HPCA total.

An expected breakdown of the activity of these 5 Councils is set out below.

Council	Complaints 12/13	Complaints 13/14	Total Complaints Managed over 12/13 and 13/14 (includes carry over from 2011/12)	Monitoring Cases Managed over 12/13 and 13/14	s150 'Hearings' over 12/13 and 13/14	Referrals to IRPs and PRPs 12/13 and 13/14	Referrals to Inquiries 12/13 and 13/14	Referrals PSCs and Tribunals 12/13 and 13/14
Dental	465	370	1079	61	23	15	68	8
Medical	1683	1774	4419	368	124	166	N/A	73
Nursing and Midwifery	453	596	1247	340	163	308	N/A	50
Pharmacy	184	192	458	57	58	41	9	6
Psychology	150	168	374	33	12	45	6	9

The Discussion Paper seeks views on whether there should be a consolidation of the nine lower complaints volume Councils. Consolidation would contribute to:

- a simplification of the overall governance structure;
- addressing financial concerns within the smaller professions through the achievement of economies of scale, reduced duplication of activities associated with operational matters eg the number of meetings, and reduced overall Council member annual fee expenses due to fewer total members, reduced reporting requirements (eg rather than nine annual reports, there would only need to be one); and
- creating a critical mass of practitioners and cases necessary to promote regulatory experience and the development of knowledge and expertise to effectively deal with immediate action cases, performance matters and improvements in health programs.

This type of consolidated approach is used elsewhere, such as in the United Kingdom where the Health and Care Professions Council successfully regulates 16 professions including podiatrists, occupational therapists, physiotherapists and psychologists, amongst a range of other professions (some of which are not registered in Australia)¹⁸.

¹⁸ Further information on the UK model can be found at www.hpc-uk.org/.

At the national level, the discussion paper on the National Review of the NRAS undertaken by Kim Snowball also considered the issue the consolidation of the nine low regulatory workload professions. That discussion paper noted that, at the national level, 5 of the professions (medicine, nursing and midwifery, pharmacy, dentistry and psychology) represented 87.5% of registrants and 95.5% of all notifications and complaints¹⁹. The national discussion paper considered that the other nine professions (chiropractors, occupational therapist, osteopaths, physiotherapist, Aboriginal and Torres Strait islander health practitioners, Chinese medicine, practitioners, medical radiation practitioners, optometrists and podiatrists) were overregulated and paid disproportionately high fees, which could be decreased if the overregulation could be addressed.

The national discussion paper considered a number of options regarding the regulation of the nine lower complaints generating professions, including the establishment of the Health Professions Australia Board to regulate the nine lower complaints generating professions. The national discussion paper considered that the establishment of a Health Professions Australia Board, together with the creation of profession specific subcommittees, would both decrease costs while preserving professional input from the different professions²⁰.

Given the canvassing of these issues in the national discussion paper, and in view of the financial implications for the smaller Councils in NSW highlighted above, this review is seeking submissions on the question of the whether the Councils for the 9 low complaints generating professions should be consolidated into a Combined Health Professional Council (Combined Council), effectively mirroring the suggestion made in the National Review.

However, it is noted that it is not clear at the time of writing what the National Review will recommend and what recommendations of the National Review Ministers will accept. As such, consideration of this issue will also be affected by the recommendations of the National Review, and their acceptance or otherwise by Ministers.

That said, given the pressing concerns of some of the smaller NSW Councils, some degree of consolidation, whether it is all 9 low complaints professions and their respective Councils in NSW or some of them, is considered to have benefits in NSW and the Ministry would like to hear submissions on the general issue of consolidation of the low complaints professions.

In respect of a possible consolidation of all 9 low complaints professions, if a Combined Council was created, the table below sets out the estimated number of registrants, complaints and fees revenue that may apply to the Councils (based on 2013-2014 figures).

¹⁹ *Review of the National Registration and Accreditation Scheme for health professions: Consultation Paper August 2014*, prepared by Kim Snowball, accessed via www.ahmac.gov.au

²⁰ The National Review of the NRAS and a response to its recommendations by the Australian Health Workforce Ministerial Council is expected to be released in late 2015. Its release may assist with consideration of the consolidation of Councils in NSW.

Combined Health Professional Council	Registrants	Complaints (2013/14 first 11 months)	Fee Revenue ('000) 2013/4	Cash ('000) (at 31/5/14) (inc E&R)	Budgeted expenditure 2013/4 ('000)
Compromising practitioners from Aboriginal and Torres Strait Islander health practice, osteopathy, podiatry, Chinese medicine, chiropractic practice, medical radiation practice, occupational therapy, optometry and physiotherapy	Around 23,000	128	\$2,484	\$3,629	\$1,732

The Ministry considers that the creation of a Combined Council, if adopted, would go a long way to ensuring the financial viability of the low complaints generating Councils. It may lead to a decrease in fees, at least for some of the professions, due to a decrease in certain costs, such as annual reporting and audit fees, lower Council fees and staffing costs.

However, the Ministry recognises that appropriate discussion and consideration of the issue is required, in particular:

- how the membership of the Combined Council would be structured – including questions about professional membership on the Combined Council or whether there are alternative membership structures to consider; and
- how a Combined Council would be structured so as to ensure that complaints against a health practitioner are considered and heard by that practitioner’s professional peers (and legal and community members as appropriate).

Both of these issues are considered further below.

3.3.1(a) Membership of a combined Health Professional Council and hearing of complaints

Currently, ensuring professional representation on Councils is a key component of the complaints system. This is because professional representation not only ensures “professional ownership” of the system, but also brings professional insight and knowledge to the complaints processes and assists in members of the profession supporting the system and respecting decisions and policies that come from the Council.

As a result, all NSW Health Professional Council have a majority representation of the relevant profession. It is also important that the community is represented and therefore most, but not all, Councils have a number of community representatives. All Councils have a legal member as well²¹.

Reproducing this level of professional representation in a combined structure would be difficult. It is likely that the overall number of Councils members would need to increase to at so as to ensure representation from all the professions which in turn may lead to a reduction in the proportional level of community representation.

To be effective, a Combined Council may need to develop a 2 level structure:

- an overall “governance council”, with a mix of clinicians and community representation; and
- subcommittees to hear and determine complaints against a practitioner, to be comprised of peer clinicians from the practitioner’s profession and community and legal representation as required.

Such a structure would allow the “governance council” to be responsible for the overall governance and strategic direction of the Combined Council while the subcommittees would meet and consider complaints against a practitioner as required. Importantly, the Ministry considers that practitioner members of the subcommittees would have to be members of the same profession as the practitioner the subject of complaint. The subcommittee would manage, hear and determine complaints in accordance with NSW specific provisions in the same way that the Councils do at the moment. This model would help ensure appropriate governance, accountability and strategic oversight of the overall Combined Council and ensure professional input when complaints are managed by the subcommittee.

However, the Ministry would like to hear views on whether a Combined Council should be established and, if so, what should be the composition of the Combined Council.

Issues for consideration?

- 3) Should the NSW specific provisions be amended to replace the existing Councils for the nine low complaints professions (Aboriginal and Torres Strait Islander health practice, osteopathy, podiatry, Chinese medicine, chiropractic practice, medical radiation practice, occupational therapy, optometry and physiotherapy) with a Combined Council?
- 4) If so, what should be composition of the Combined Council?
- 5) If a Combined Council is established, should the NSW specific provisions be amended to require a complaint against a health practitioner to be heard and determined by a subcommittee of the combined health profession Council comprised of members of the practitioner’s profession as well as having access to community and legal members to sit on any complaint as appropriate?

3.3.2 Where a Council is not financially viable

The model of NRAS is one where the costs associated with running the NRAS scheme, including the Health Professional Councils in NSW, are financially independent of the

²¹ The current composition of the Councils is set out in the Health Practitioner Regulation (New South Wales) Regulation 2010 at clause 4 and Schedule 1A

Government. That is, the regulatory system is intended to be self-funded with the fees generated from registrants from each profession financially supporting the Councils, the National Boards, AHPRA and HPCA.

However, as noted above, the Aboriginal and Torres Strait Islander health profession has not to date been self-funded and the current scheme can result in financial difficulties for the smaller professions.

As such, regardless of whether or not a larger combined health practitioner Council is established in NSW, consideration must be given to how to regulate the smaller professional groups such as the Aboriginal and Torres Strait Islander health profession, where the fees that can reasonably be generated from registrants do not cover the costs of running the Council.

The Ministry's preliminary view is that some form of "future proofing" of the legislation is required to deal with the situation of a Council that is not financially viable. This could be done by way a regulation making power that allows regulations to be made amending the complaints handlings, administrative or other processes for a particular profession in the event that a Council is not financially viable. The benefit of having a regulation making power is that the regulations can be appropriately drafted to meet the needs of the different professions as required. However, consideration would need to be given to what form of consultation and public notice would be required before any regulation is made.

For example, in respect of the Aboriginal and Torres Strait Islander health profession, there are a number of options to deal with the financial constraints facing the Council:

- 1) The administrative and reporting obligations of the Aboriginal and Torres Strait Islander Health Practice Council are transferred to another larger Council while the statutory committees and professional panels of the Aboriginal and Torres Strait Islander Health Practice Council are retained. Given that, to date, there has been an absence of any regulatory activity of the Aboriginal and Torres Strait Islander profession, the burden to the larger Council would be expected to be minimal.
- 2) More specific regulations are made to address issues such as when meetings should be held, fees to be paid and reporting requirements all of which may assist in reducing costs. Consideration would need to be given to what form of consultation and public notice would be required before any regulations were made. This option would maintain the regulatory processes for Aboriginal and Torres Strait Islander health profession while dealing with the issues relating to the financial unviability of a standalone Aboriginal and Torres Strait Islander Health Practice Council.
- 3) The complaints handling processes for the Aboriginal and Torres Strait Islander health profession is given to the HCCC. This would not be expected to increase costs of either the HCCC or the Aboriginal and Torres Strait Islander health profession due to the smaller number of practitioners and expected low number of complaints.

However, the HCCC does not have established processes for dealing with impairment or performance issues and is therefore not the preferred approach of the Ministry at this time.

The Ministry would like to hear views on how to “future proof” the legislation to deal with a situation where a Council is not financially viable.

Issues for consideration?

- 6) If a consolidated Health Professional Council is not created, should the legislation be amended to “future proof” the legislation in order to deal with the situation of a Council being financially unviable?
- 7) If so, should a regulation making power be included allowing regulations to be made amending the complaints handling processes for a profession in the event that the Council for that profession is not financially viable?
- 8) In respect of the Aboriginal and Torres Strait Islander Health Practice Council, what changes should be adopted to address the financial constraints of the Council?

3.4 Part 8: Health, Performance and conduct

Part 8 of the Health Practitioner Regulation National Law (NSW) deals with health, performance and conduct of health practitioners.

The Health Professional Councils currently operate three separate and largely distinct complaints management streams each of which is provided for in the NSW specific provisions. Those streams are conduct, performance and health.

The management of each of these streams by the Councils is, despite some similarities and crossovers, largely distinct:

- **The conduct stream** operates through NSW Civil and Administrative Tribunal (Tribunal) hearings for all professions; Professional Standards Committee (PSC) hearings for the medical profession and the nursing and midwifery professions; and through NSW Tribunal hearings and Council disciplinary inquiries for all professions other than medical, nursing and midwifery.
- **The performance stream** operates through performance assessments and performance review panels in all professions.
- **The health stream** operates through impaired registrants panels, with conditions or suspensions being imposed (with consent) by the relevant Council, for all professions.

Although not the general focus of this Paper, it should be remembered that the HCCC plays a large and important role in the complaints processes. The HCCC is the independent public interest investigator and prosecutor of serious complaints against registered health

practitioners and also plays an important role in consulting with the professional Councils on the management of health, performance and lower level conduct complaints.

In other States and Territories, conduct matters are dealt with by a relevant Tribunal or at the lower end by a Performance and Professional Standards Panel; performance matters are dealt with by a Performance and Professional Standards Panel; and health matters are dealt with by a Health Panel.

This paper considers what, if any, amendments to the NSW specific provisions could be considered to maintain and improve the effectiveness of the complaints process in NSW.

More broadly, the Ministry would like to hear submissions on the current effective separation of the different streams and whether it would be more effective to try and deal with any and all issues a practitioner may be facing in one stream. For example, a practitioner may have both impairment and performance issues, rather than dealing with these two issues separately via the performance stream and the health stream, should there be one fitness to practice panel that can consider both issues facing the practitioner?

Issues for consideration?

- 9) Is the current complaints model whereby there are different and distinct streams, health, conduct and performance, to deal with complaints appropriate and effective?

3.4.1 The conduct stream

The conduct stream deals with complaints against health practitioners that relate to lower level allegations of unsatisfactory professional conduct as well as higher level allegations of professional misconduct.

3.4.1 (a) Lower level complaints: PSCs and Council Inquiries

Professional Standards Committees

The medical, nursing and midwifery professions have access to PSC to deal with lower level complaints relating to conduct matters. PSCs are intended to provide a less formal and legalistic alternative to Tribunal hearings to deal with lower level complaints. There are a number of differences between PSCs and Tribunal hearings, including:

- PSCs cannot make findings of professional misconduct and therefore cannot suspend or cancel a practitioner's registration (although they can make recommendations regarding suspension or cancellation);
- PSCs cannot award costs; and
- appeals are to the Tribunal rather than to the Supreme Court.

However, it has been argued, that over the years, PSCs have evolved to become more legalistic and formal and that the distinctions between Tribunal hearings and PSCs have lessened.

In 2008 amendments were made to the old Medical Practice Act 1992 to increase the size of PSCs to 4 members by the addition of a senior legal member as the Chairperson; to provide that inquiries were to be heard in public; and to provide that decisions of the PSC where the complaint was proven in whole or part were to be made public. In 2009 further amendments were made to allow for parties to be represented by lawyers. With the Commencement of the Health Practitioner Regulation National Law (NSW) in July 2010 these amendments were rolled out to nursing and midwifery PSCs. PSCs are also run along more formal lines, compared to Council inquiries, with the HCCC appearing as the contradictor and prosecutor in PSC matters.

Council inquiries

Council inquiries are utilised by all Councils other than medical and nursing and midwifery. Council inquiries have a long history having their origins in former NSW Board inquiries which were the highest order of disciplinary proceeding in the days before Tribunals. Previously many of the professions that utilised Board inquiries for the most serious complaints also had professional standards committees to address the lower order conduct complaints.

With the progressive establishment of Tribunals for all of the professions between 1991 and 2007 (the Medical Profession has had a Tribunal since 1938), Board inquiries were downgraded from dealing with the most serious matters, and consequently having the power to cancel registration, to dealing with the less serious level of complaint.

In many respects Council inquiries takes the place of PSCs – that is the Council inquiries deal with lower level conduct matters and do not have the power to make findings of professional misconduct. They can, again as with PSCs, only make a recommendation to suspend or cancel a practitioner's registration. However it is also important to recognise that those Councils that use Council inquiries are also the Councils that prior to 1 July 2010 did not have access to the performance stream. Accordingly, in practice today many of the matters dealt with by Council inquiries incorporate an element, sometimes a significant element, of unsatisfactory professional performance.

As noted above, in other States and Territories, the lower level conduct complaints are dealt with by Performance and Professional Standards Panels. The National approach also recognises that low level conduct matters often contain an element of poor performance.

Council inquiries are often run on a more informal basis than PSCs. While the HCCC has the capacity to appear at Council inquiries if the Council agrees, or to make written submissions

to such an inquiry²², it generally does not do so. Rather, the Council drafts the formal complaint and is the decision maker. It is noted that Council inquiries are not open to the public and decisions are not recorded and so there is arguably Council inquiries are less transparent than PSCs.

Issues arising

The Ministry received a number of preliminary comments on issues relating to PSCs and Council inquiries.

In respect of PSCs, some argued that the distinction between PSCs and Tribunal hearings have lessened over the years such that there is no meaningful distinction between the two. Accordingly it was argued that consideration should be given to abolishing PSCs and either moving their functions to Council inquiries or the Tribunal. This is by no means a universal view as others have indicated a strong preference to retain PSCs in the current form and have argued that PSCs do represent a good informal mechanism for dealing with lower level complaints. In this respect it is noted that PSCs are separated constituted bodies that are independent of the Council and the HCCC.

Other views also exist. One of the preliminary submissions received argued that PSCs should have a broader remit and be allowed to suspend or cancel a practitioner's registration and that PSC hearings should be recorded so as to assist in appeal matters. It has also been suggested that amendments should be made, to s146E, giving PSCs the power to deal with contraventions of conditions imposed by a PSC directly rather a PSC having to refer the matter to the Tribunal.

In relation to Council inquiries and PSCs, are these the appropriate body to deal with lower level conduct matters at all? Should instead the Tribunal hear all complaints relating to conduct matters?

Against these issues is the broader question of whether it is appropriate to have different processes, PSCs or Council inquiries, for dealing with complaints relating to a practitioner's professional conduct depending on the profession in which a practitioner is registered.

In relation to the question of whether it is appropriate to have different complaints processes depending on what profession a person is registered in, it can be argued that the differences in processes are mainly historical in nature (and depend on the relevant health professional registration Act at the time of the establishment of NRAS) and therefore could be harmonised among the different professions.

On the other hand, in relation to PSCs, particularly for medical practitioners, the provisions have undergone a number of changes over the years to respond to various issues that have developed. As such, it can be argued that the PSCs provisions have been appropriately

²² See s148D of the Health Practitioner Regulation National Law (NSW)

adapted for the medical, nursing and midwifery professions and that it is entirely appropriate for these provisions to be different to those applying to other professions.

In the Ministry's view, while consistency is important, it is more important to ensure that the processes and provisions in the NSW specific provisions:

- are suitable and appropriate to protect the public;
- resolve complaints in a timely manner;
- are cost effective; and
- give appropriate due process and natural justice to practitioners the subject of a complaint.

Thus the question for the Ministry is what changes, if any, are required for PSCs and Council inquiries to ensure that complaints are dealt with in a timely, cost effective manner that both protects the public and ensures natural justice for practitioners the subject of a complaint.

Issues for consideration?

- 10) What changes, if any, are required for PSCs and Council inquiries to hearing complaints in a timely, cost effective manner that both protects the public and ensures natural justice for practitioners the subject of a complaint?

3.4.2 The health stream

Where a complaint raises concerns that a practitioner has an impairment, the complaint can be dealt with under Division 4 of Part 8 of the Health Practitioner Regulation National Law (NSW). Such a complaint can then be dealt with under the health stream by an Impaired Registrants Panel.

The health stream, and the use of Impaired Registrants Panels, was first introduced in 1992 as Part 5 of the Medical Practice Act 1992 "Alternatives to Disciplinary Procedures". The health program was then rolled out to the nursing and midwifery professions in 1996 and to all other professions progressively between 2001 and 2007.

Two main issues have been raised with respect of the health stream and the Impaired Registrants Panel. These issues relate to the composition of an Impaired Registrants Panel and the powers of the Panel.

3.4.2 (a) Composition of an Impaired Registrants Panel

Under s173A of the Health Practitioner Regulation National Law (NSW), Impaired Registrants Panels comprise two or three persons and must include at least one person from the relevant profession and at least one medical practitioner. The requirement that a Panel include a medical practitioner reveals the origins of the program in the medical profession

and the need to appropriately manage issues that typically arise in the health program such as substance abuse, mental health and cognitive decline.

However, it has been suggested that the requirement to include a medical practitioner on the Panel is no longer required. It has been argued that a blanket requirement for a medical practitioner on all Panels does not necessarily result in the effective and efficient operation of the health stream. This is because practitioners who are before a Panel have routinely been subject to assessment and a report from a Council appointed practitioner who is usually a medical practitioner (often a psychiatrist), but might also be a psychologist. In addition, requiring a medical practitioner to sit on all Panels means that a small number of medical practitioners who are skilled and knowledgeable about the impairment system are often called on regularly. The availability of those practitioners can be limited thereby reducing flexibility and efficiency and cause delays. The use of medical practitioners can also increase costs which can impact particularly on the smaller professions.

On the other hand, medical practitioners will arguably be the best placed profession to deal and manage the common issue of substance abuse, mental health and cognitive decline that affect practitioners who are before a Panel and therefore it may be appropriate for the current composition requirements to remain.

In view of these issues, the Ministry is seeking submission on the appropriate constitution of an Impaired Registrants Panel.

Issues for consideration?

- 11) Should the requirement that a medical practitioner sit on an Impaired Registrants Panel remain in the legislation?
- 12) If not, what should be the composition of the Panel?

3.4.2 (b) Powers of an Impaired Registrants Panel

Issues have also been raised regarding the powers of an Impaired Registrants Panel.

On the one hand, some have noted that the Panel's power under s152I to counsel the practitioner or recommend that conditions be placed on the practitioner's registration is not dependent on the Panel actually finding that the practitioner is impaired. The Panel's power should arguably therefore be amended to limit a Panel's power to only the circumstances where the Panel finds a practitioner is impaired.

On the other hand, it has also been suggested that consideration should be given to expanding the power of an Impaired Registrants Panel to take action directly, rather than only being empowered to make recommendations.

Impaired Registrants Panels are an important part of the complaints process in NSW and it is important to get the balance right between the protection of the public, the rights of

practitioners while ensuring that complaints that raise impairment issues are handled in a cost effective, fair and timely manner. As such, the Ministry is seeking submissions on what, if any, changes should be made to the powers of Impaired Registrants Panels.

Issues for consideration?

- 13) What changes, if any, are required to the Impaired Registrants Panel, particularly in respect of the powers of the Panels, to ensure that complaints that raise impairment issues are handled in a cost effective, fair and timely manner?

3.4.3 Performance stream

The performance stream was first introduced to the Medical Practice Act in 2000. The program was extended to the nursing and midwifery professions in 2004 and was rolled out to all professions with the introduction of the National Scheme in July 2010.

The performance program is designed to provide an environment in which individual performance deficits, not amounting to unsatisfactory professional conduct, can be identified and addressed in a supportive environment. The performance program has continued largely unchanged since its introduction and allows a Council to require a practitioner to undergo a performance assessment if a Council considers a practitioner's professional performance may be unsatisfactory. Matters that raise significant issues of public health or safety or raise a prima facie case of professional misconduct cannot be dealt with by way of a performance assessment²³. Following the assessment, an assessor assesses the performance of the practitioner and provides a report to the Council. The Council can then take a variety of different actions, including deciding to take no further action, refer the matter to a Performance Review Panel or order the practitioner to undertake counselling²⁴.

Performance is well established in the Medical Council and the Nursing and Midwifery Council. However, some other Councils use performance to a limited extent, or not at all. It is noted that the performance stream is not extensively utilised in National Board jurisdictions.

It is not entirely clear why performance assessments and reviews have not been widely embraced. It could be that there is a perception that performance assessments and reviews are complex, time consuming and expensive processes. However, managing performance issues in general, be it through the performance stream or a Council inquiry process can be complex, time consuming and expensive.

There may be some minor modifications that can be made to the overall performance process to streamline its operation and thereby result in it operating more expeditiously and

²³ Section 154A of the Health Practitioner Regulation National Law (NSW)

²⁴ Section 155C of the Health Practitioner Regulation National Law (NSW)

cost effectively thereby promoting greater usage. Such amendments might also be beneficial for those Councils that extensively utilise performance by reducing costs and complexity.

One option for modification of the program is to enlarge the role of the performance assessors and abolish Performance Review Panels. This option would have the following steps:

1. Performance assessment.
2. Interim Report
 - 2.1. If the performance assessor identifies performance deficits they provide their interim report with proposed conditions to the practitioner and invite the practitioner to show cause as to why those conditions should not be imposed on his or her registration.
 - 2.2. If no performance deficits are identified the interim report is provided to the practitioner for noting and any comments.
3. Following receipt of any submissions from the practitioner, a final report and recommendations is made to the Council. The Council (or its delegate – eg the Performance Committee) has the power to impose recommended conditions without further inquiry.

This approach would streamline the performance process and reduce the cost by eliminating a significant step, the convening of a Performance Review Panel (PRP).

The above modification is simply one option for change. There may be good reason to retain PRPs in the process and there are no doubt a range of other actions that might be taken to improve or streamline the process.

However, streamlining the process would also allow resources, both staff and financial, to be refocused on conducting performance assessments and thereby contribute to more expeditious management of matters.

Steps that streamline the performance program for Councils and increase its attractiveness will also have the benefit of reducing – or eliminating – any need for Assessment Committees to undertake skills assessment. This issue is discussed below.

Issues for consideration?

- 14) Should the Performance Review Panels be abolished?
- 15) Are there other options to simplify and streamline the processes while maintaining the effectiveness of the Performance Stream?

3.4.4 Assessment Committees

The above discussions about PSCs and Council Inquiries and the discussion about modifications to the performance program lead to a discussion of the ongoing role of Assessment Committees and skills testing.

Council Inquiries, Assessment Committees and skills testing are tools that are available to those 12 Councils that do not have access to professional standards committees (that is, all Councils except for the Medical Council and the Nursing and Midwifery Council). Those 12 Councils are also the Councils that before 1 July 2010 did not have access to the performance program.

As noted above while there is capacity for the HCCC to intervene in complaints before Council Inquiries it is understood that this does not generally occur. As the HCCC does not become involved in Council Inquiries, the Councils require a mechanism via which complaints can be investigated and appropriate material compiled to bring before an Inquiry.

The mechanism that is often used to investigate these matters is the various Councils' Assessment Committees. As Assessment Committees are utilised as a precursor to Council inquiries, the Committees are most appropriately thought of as sitting within the conduct stream. However, Assessment Committees, and the subsequent Council inquiries, are often utilised for complaints that raise elements of performance.

Assessment Committees can also undertake skills testing of practitioners (see s.147C). Skills testing by Assessment Committees was introduced as a simplified performance assessment process shortly after the Medical Board's performance program was introduced. Skills testing allowed for identified performance deficits to be brought before Council Inquiries. All Councils now have access to the performance program and the HPCA has within its staff significant experience and expertise in running performance matters. As such, the Review is seeking submissions on whether Assessment Committees should be retained or if alternate structures should be adopted.

Issues for consideration?

- 16) Should Assessment Committees be retained in the NSW specific provisions?
- 17) Should alternative structures be adopted?

3.5 Section 150 processes

Section 150 of the Health Practitioner Regulation National Law (NSW) allows a Council to take action to impose conditions on a practitioner's (or a student's) registration or to suspend that registration where it is *appropriate to do so for the protection of the health or*

*safety of any person or persons (whether or not a particular person or persons) or if satisfied the action is otherwise in the public interest*²⁵.

Under s150, Councils can take action in circumstances where there is no need to prove that the practitioner is actually guilty of some form of misconduct; that he or she suffers from an impairment; or that his or her performance is inadequate. The only thing that is required is that the Council must be satisfied that it is appropriate to take action to protect a person or persons or that the action is otherwise in the public interest. It is also noted that s150 action is effectively only interim action, with the matter being required to be referred to the HCCC for investigation, Impaired Registrants Panel or Performance Panel²⁶. In addition, the practitioner has a right of review of any action taken under s150²⁷.

The s.150 process is also known as “immediate action”. Similar provision exists in the National Law jurisdiction²⁸.

While immediate action can be taken under s150 without proving misconduct, impairment or that a practitioner’s performance is inadequate, practitioners are still entitled to procedural fairness. The rules of procedural fairness are flexible and adaptable to the circumstances of each individual case. Therefore while some instances may warrant a face to face meeting with the practitioner others may appropriately and efficiently proceed on the papers.

In the National Board jurisdictions, the issue of procedural fairness is in large measure addressed by the inclusion in the National Law of a “show cause” process whereby practitioners or students are given an opportunity to make submission.²⁹ Of course the show cause process does not preclude National Boards from conducting face-to-face inquiries in appropriate circumstances and it is not necessarily the beginning, middle and end of procedural fairness, but it does mean that matters are more frequently determined “on the papers”.

NSW has a more flexible approach whereby Councils can tailor their approach, and natural justice requirements, to the circumstances of the particular case and the risk to the public.

The s150 procedures are an important part of the interim processes which works to protect the public. However, the Ministry is also aware of the need to protect the rights of practitioners so as to ensure that practitioners (and students) receive a fair hearing. Accordingly, the Ministry is seeking submissions on whether changes are required to ensure that immediate action can be undertaken to protect the public while still ensuring natural justice for practitioners.

²⁵ Section 150(1) of the Health Practitioner Regulation National Law (NSW)

²⁶ See subdivision 7, division 3 of Part 8 of the Health Practitioner Regulation National Law (NSW)

²⁷ Section 150A of the Health Practitioner Regulation National Law (NSW)

²⁸ See sections 155-159 of the National Law

²⁹ See ss157 and 158 of the National Law

Issues for consideration?

- 18) Are changes required to s150 to ensure that immediate action can be taken to protect the public while still ensuring natural justice for practitioners?

3.6 Tribunals

On 1 January 2014, the Civil and Administrative Tribunal Act 2013 commenced and each of the previous 14 individual health profession Tribunals, including the Medical Tribunal and the Nursing and Midwifery Tribunal, ceased to exist and were replaced by the single Civil and Administrative Tribunal of New South Wales (also known as NCAT).

Some preliminary submissions raised issues with a number of current provisions relating to the role, powers and functions of the Tribunal. In many cases, the issues raised call for minor “tidy up” amendments. These, and other “tidy up” amendments the Ministry is proposing, are set out in Appendix A.

However, a number of more substantive issues were also raised relating to the Tribunal processes which are set out below for consideration.

3.6.1 Power of the Tribunal to take interim action

Section 149A of the National Law sets out the general powers of the Tribunal to caution, reprimand, counsel, impose conditions, order the practitioner/student to undertake an educational course. As well as the Tribunal being able to exercise these powers at the conclusion of proceedings, the Tribunal can also, in accordance with s165L, exercise these powers on an interim or “interlocutory” basis during a hearing. However, the interim powers of the Tribunal under s165L do not extend to the Tribunal being able to suspend a practitioner or student.

It has been suggested that s165L should include a power to make an interim suspension order. This is because in complex matters that may take months to finalise, an interim suspension order may be appropriate to protect the public where the evidence presented indicates that the practitioner is not safe to practice. This may be particularly the case where the Tribunal has found that a practitioner is impaired or not competent to practice but the matter is then adjourned in order for the Tribunal to prepare its decision on the final orders to be imposed.

The Ministry’s preliminary view is that there are good reasons for considering such a change in circumstances where there is a clear public protection issue. For example, if the Tribunal has reached the point of making a finding of misconduct, fitness or competence that raises public protection issues and that the finding is sufficient to warrant consideration of cancellation or suspension of registration, it would be appropriate to enable the Tribunal to consider an interim suspension order during any interim period between the finding and the final orders. However, if such an amendment was made, it would also be necessary to consider what safeguards, or appeal rights, should be included in the legislation.

However, prior to the Tribunal making a finding that a practitioner has engaged in misconduct or is not fit or competent to practice, the Ministry has concerns about giving the Tribunal a power to make an interim suspension order. This is because, arguable the Tribunal's powers under s165L are broad enough to appropriately protect the public by allowing the Tribunal place conditions on the practitioner's practice or make other appropriate orders on an interim basis.

The Ministry would like to hear submission on this issue.

Issues for consideration?

- 19) Should the Tribunal have a power to make an interim suspension order?
- 20) If so, in what circumstances should the Tribunal be able to make an interim suspension order?
- 21) If the Tribunal has a power to make an interim suspension order, what safeguards or appeal rights should be included in the legislation?

3.6.2 Role and powers of the Tribunal where complaints are admitted

Under s165H, the Tribunal is not required to conduct an inquiry if the complaint has been admitted in writing. However, Part 8 does not detail any further what the Tribunal should do in such cases.

One of the preliminary submissions suggested Part 8 could be amended to clearly articulate the functions and powers of the Tribunal in matters where a complaint has been admitted, in particular whether the Tribunal can receive and consider evidence relating to the factual circumstances and whether the Tribunal should give reasons when deciding to make protective orders such as cancellation or suspension.

Where a complaint has been admitted by a practitioner, there may still be issues that need to be resolved by the Tribunal, in particular what are the actual factual circumstances surrounding the complaint, which may require some form of an inquiry. Section 165H does not preclude such an inquiry being conducted, however it has been argued that it may be beneficial to clearly set out the role and powers of the Tribunal in such cases. On the other hand, if the Act does not preclude an inquiry being conducted, is there actually a need to amend the Act?

In relation to giving reasons, the Ministry's preliminary view is that there are strong arguments to support a requirement for the Tribunal to give reasons relating to the imposition of a protective order even when a complaint is admitted. Written reasons will help the public, and the practitioner, understand why an order has been imposed. It would also assist practitioners, and the Court, if a practitioner wishes to appeal a decision of the Tribunal relating to imposition of a protective order, such as suspension or cancellation.

The Ministry would like to hear from stakeholders as to whether Part 8 should be amended to clarify that the Tribunal can still hold an inquiry where a complaint has been admitted and that the Tribunal should provide written reasons where protective orders are made in circumstances where a complaint has been admitted.

Issues for consideration?

- 22) Should Part 8 of the Health Practitioner Regulation National Law (NSW) be amended to clarify that the Tribunal can hold an inquiry where a complaint has been admitted?
- 23) Should a new section be included in Part 8 requiring the Tribunal to give written reasons when making orders in circumstances where a complaint has been admitted?

3.6.3 Parties to an application for review

Section 163A gives a right of review, to an appropriate review body, to practitioners that are subject to a prohibition order, suspension, disqualification or an order imposing conditions. The appropriate review body will be either the Tribunal or a Health Professional Council. While the legislation states that a practitioner has a right of review, there is a lack of clarity in the legislation regarding who would be, or could be, the respondent to such a review. This is because there is nothing in the Act to formally state who has a party to the review or who has a right to appear. Rather, the HCCC or a Council will seek leave from the Tribunal to be joined as a party to the review under the Civil and Administrative Tribunal Act 2013. Requiring the HCCC or the Council to seek leave to be joined as a party can increase costs and the lengths of hearings.

This can be contrasted with other sections of the Health Practitioner Regulation National Law (NSW) which make clear who are parties to the proceedings and who has a right to be heard. Clause 9 of Schedule 5D of the Health Practitioner Regulation National Law (NSW) provides that in any proceedings before a Tribunal or PSC, the HCCC can act as the nominal complainant. Clause 10 of Schedule 5D gives the Director-General (now Secretary) a right to intervene or be heard in any matter before a Tribunal or PSC. There are also powers of the HCCC to make submissions and attend a Council hearing when the Council is dealing with a complaint³⁰.

The Ministry is seeking submissions on the question whether the legislation should be amended to clarify who should have a right to appear before, or be heard, in matters where an application for a review is made under s163A and, if so, who that person or body should be.

³⁰ See section 148D of the Health Practitioner Regulation National Law (NSW).

Issues for consideration?

- 24) Should the legislation be amended to clarify who should have a right to appear before, or be heard, in matters where an application for a review is made under s163A?
- 25) If so, who should be that person or body?

3.7 Deciding not to conduct an inquiry or appeal or to terminate an inquiry or appeal

Under clause 12 of Schedule 5D, a PSC or a Tribunal may decide not to conduct an inquiry or to terminate an inquiry or appeal in a number of circumstances, including where “*in the opinion of the [PSC] or Tribunal it is not in the public interest for the inquiry or appeal to continue*”.

One of the preliminary submissions suggested that clause 12 of Schedule 5D should be amended to give a list of criteria a PSC or a Tribunal should consider in forming their opinion that it is not in the public interest for an inquiry or appeal to continue.

The notion of “public interest” is a broad one, although generally factors such as the risk to the public, deterrence, costs and the benefits of having public reasons will be, and should be, considered. A list of criteria may therefore be useful in ensuring consistency and transparency of decision making. However, what factors a PSC or a Tribunal will, and should, consider in determining whether or not it is in the public interest for a matter to proceed to an inquiry or an appeal will depend on the circumstances of each case. As such, setting out a list of mandatory criteria for a PSC or Tribunal to consider may not be beneficial.

In relation to this issue, it is also noted that section 3A of the Health Practitioner Regulation National Law (NSW) is of relevance. Section 3A, which is a NSW specific provision, states that:

In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.

Section 3A would apply to any decision not to proceed with an inquiry or an appeal by a PSC or a Tribunal. That is, at the heart of the PSC’s or Tribunal’s decision making, the protection of the health and safety of the public should be the prime consideration, although there will be a range of other factors, that will depend on the circumstances of each case, that will also need to be considered.

The Ministry’s preliminary view, therefore, is that it is not necessary to amend clause 12 of Schedule 5D to set out a list of criteria that should be considered by a PSC or a Tribunal in determining whether it is not in the public interest for an inquiry or appeal to continue. However, the Ministry would like to hear submissions on this issue.

Issues for consideration?

- 26) Should Schedule 5D clause 12 be amended to give a list of mandatory factors a PSC or Tribunal must consider in determining whether it is not in the public interest for an inquiry or appeal to continue?

3.8 When practitioners change their place of residence

The NSW specific provisions relating to complaints handling apply to:

- (a) conduct that occurs in NSW; and/or
- (b) registered health practitioners whose principal place of practice is in NSW.

A number of preliminary submissions raised issues regarding the processes in place to deal with practitioners, particularly those subject to conditions, who change their principal place of practice or residence.

If a NSW health practitioner is subject to conditions imposed under the Health Practitioner Regulation National Law (NSW), the conditions apply across Australia. Likewise, if a non-NSW health practitioner is subject to conditions imposed under the National Law in another State or Territory, the conditions apply in NSW. However, the management of such conditions can become complicated when a practitioner changes their principal place of practice or residence.

If the conditions were imposed in NSW an order can be made allowing the National Board to review and remove/amend conditions in the event that the practitioner changes jurisdictions. However no such flexibility exists for conditions imposed by a National Board or by an adjudication body in another jurisdiction. This results in a number of administratively regimes having been developed to work around those limitations that can be complex for practitioners and Councils.

The Ministry would like to hear views as to whether the current administrative arrangements are adequate or express provisions are required in Part 8 to deal with the interstate movement of practitioners. That said, it is noted that some of the issues relating to the interstate movement of practitioners may not be dealt with unilaterally by changes to the NSW specific provisions (particularly in cases where a NSW practitioner moves interstate) and may instead require changes to the National Law.

Issues for consideration?

- 27) Are the current administrative arrangements for dealing with practitioners who have conditions on their registration adequate or are legislative amendments required?
- 28) If legislative amendments are required, what changes are needed?

3.9 Mandatory notifications

3.8.1 Treating health practitioners and mandatory notifications

Division 2 of Part 8 relates to mandatory notifications and these provisions are not NSW specific provisions. Under the provisions, certain conduct and concerns must be notified to AHPRA. Such mandatory notifications include, at s141, where a health practitioner forms the reasonable belief that a registered practitioner who is a patient has engaged in “notifiable conduct”. Notifiable conduct means that the practitioner has³¹:

- practised the practitioner’s profession while intoxicated by alcohol or drugs; or
- engaged in sexual misconduct in connection with the practice of the practitioner’s profession; or
- placed the public at risk of substantial harm in the practitioner’s practice of the profession because the practitioner has an impairment; or
- placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

In all states other than Western Australia and Queensland, the obligation to report to AHPRA under s141 applies equally to a practitioner’s treating health practitioner. In Western Australia there is a blanket exemption for treating practitioners³². In Queensland, there is an exemption for treating practitioners where the treating practitioner does not believe the public is at substantial risk or there is professional misconduct³³.

Preliminary comments received by the Ministry indicated a level of concern among some stakeholders that there is not an exemption for treating practitioners in NSW. The issue of mandatory notification was also considered in the national discussion paper on the National Law.

The argument given for giving an exemption to the mandatory notification requirements to treating practitioners is that the current requirements can be counterproductive in protecting the public as it may deter practitioners from seeking treatment. The Ministry is not aware of any evidence on which this claim is based or on any surveys or reviews that lend weight to the claim.

Mandatory reporting was first introduced into NSW for medical practitioners in 2008. As such, it was the first State to consider this type of reporting. As noted at the time³⁴, and in

³¹ Section 140 of the Health Practitioner Regulation National Law (NSW)

³² Section 141(4)(da) of the Health Practitioner Regulation National Law (WA)

³³ Section 141(5) of the Health Practitioner Regulation National Law (Qld)

³⁴ See the second reading speech for the Medical Practice Amendment Act 2008 – Hansard 7 May 2008:

http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LA20080507005?open&refNavID=HA4_1

the current National Board Guidelines, these obligations simply reflect what was already an ethical obligation under the code of conduct.

The Ministry remains of the view that mandatory notification helps protect the public by ensuring that practitioners' whose conduct places the public at risk of harm are notified to the AHPRA. It is also important to recognise that the threshold for mandatory reporting is quite high: the practitioner must have a reasonable belief that the other practitioner has engaged in notifiable conduct.

Where the conduct involved relates to impairment, the mandatory notification provisions will only apply if the practitioner has placed the public at risk of substantial harm in the practitioner's practice because the practitioner has an impairment. This is not a low threshold. It is difficult to see how it could ever be appropriate for a treating practitioner not to report another patient practitioner if the treating practitioner had a reasonable belief that the patient practitioner was placing the public at risk of substantial harm in the practitioner's practice due to the patient practitioner's impairment. Further, even if the treating practitioner did not have a mandatory obligation to report such conduct, it is highly likely that there would be an ethical obligation to report.

As noted above, medical practitioners in NSW, including treating practitioners, have had a requirement to report similar conduct since 2008 under the old Medical Practice Act³⁵. Reference is also made to s3A of the Health Practitioner Regulation National Law (NSW) which makes clear that the protection of the public is the paramount consideration in this area. If a treating practitioner forms the view that a practitioner patient has engaged in notifiable conduct, in order to protect the public, a notification to AHPRA should be made so that the relevant body can investigate the matter.

As such, the Ministry's preliminary view is that no changes to these requirements are required. However, the Ministry recognises that there are concerns among some practitioners and professional organisations about the mandatory reporting requirements and treating practitioners. These concerns may be based, at least to some extent, on a misunderstanding about the threshold level for mandatory reporting, particularly when the reporting concerns a practitioner with an impairment. An impairment in and of itself is not grounds for a mandatory report. Rather, there needs to be a reasonable belief that the practitioner has placed the public at risk of substantial harm in the practitioner's professional practice because of their impairment. It may be that further information needs to be provided in order to ensure that the mandatory reporting provisions are properly understood.

In view of the preliminary comments received, the Ministry is seeking comments on how best to protect the public from practitioners who may be placing the public at risk of substantial harm in their professional practice because of the practitioner's impairment.

³⁵ See s71 of the repealed Medical Practices Act 1992

Issues for consideration?

- 29) What is the best way to protect the public from practitioners who may be placing the public at risk of substantial harm in the professional practice because of the practitioner's impairment?
- 30) Are any changes to the legislation required?
- 31) Should there be additional information provided to practitioners to ensure that they understand their mandatory reporting obligations?

3.8.2 Referral of mental health matters to Councils

Under s151 of the Health Practitioner Regulation National Law (NSW), if a registered health practitioner or student becomes a "mentally incapacitated person" or is "involuntarily admitted to a mental health facility", the NSW Trustee and Guardian (in the case of mentally incapacitated persons) or the medical superintendent of the mental health facility must notify the Executive Officer of the relevant Health Professional Council.

Section 151 is a NSW specific provisions that is very broadly drafted. It requires notification to a Council where a registered health practitioner or student is "involuntarily admitted to a mental health facility".

Under the Mental Health Act 2007, a person can be "involuntarily admitted to a mental health facility" in a range of different circumstances under the Mental Health Act, including where a "schedule" is written by a medical practitioner or where a person is brought into a mental health facility by a police officer or ambulance³⁶.

However, it is important to note that the initial detention of a person in a mental health facility is generally on the basis that one person has made a determination that the patient is a mentally ill person or mentally disordered person. As such, the Mental Health Act requires a range of checks and balances to occur so that on-going detention in a mental health facility is subject to further assessments by medical practitioners carried out under s27 of the Mental Health Act. If those assessments under s27 of the Mental Health Act find that the patient is a mentally ill person, the patient must be brought before the independent Mental Health Review Tribunal who makes the final determination as to whether the patient is a mentally ill person and whether that person should be detained.

Currently, the requirement to notify the Council in s151 is activated the moment that the practitioner is initially involuntary detained in the mental health facility. That is, before the patient has been reviewed under s27 (and such reviews might result in the patient being found not to be a mentally ill person and being released) or before the patient's detention has been reviewed by the Mental Health Review Tribunal.

As the requirement to notify the Council in s151 occurs at such an early stage in the process under the Mental Health Act (and before the patient has been properly assessed), there

³⁶ See Division 2 of Part 2 of the Mental Health Act 2007

may be arguments that it is not appropriate for there to be a specific reporting requirements separate from the more general mandatory reporting requirements. Another option is that if such a reporting requirement should remain, the mandatory notification should only occur if a patient is detained in a mental health facility either following the s27 assessments or following the Mental Health Review Tribunal hearing. Of course, if the patient otherwise met the criteria for a mandatory notifications under s141, or if other circumstances warranted notification or a complaint to the Council or the HCCC, this should still occur.

It is noted that under the old Medical Practice Act, the requirement to report only applied to mentally incapacitated persons, which would only relevantly include persons found to be a mentally ill person after the Mental Health Review Tribunal inquiry³⁷.

Issues for consideration?

- 32) Should the reporting requirements of medical superintendents under s151 remain?
- 33) Should s151 of the National Law be amended to require the medical superintendent to notify a health practitioner Council of a registered health practitioner or student who is detained in a mental health facility under the Mental Health Act only after either the s27 examinations have occurred or the patient has been seen Mental Health Review Tribunal?

3.10 Requirement of National Board to keep a register of disqualified practitioners

Under the National Law, there is a requirement for a National Board to keep public registers of practitioners whose registration has been cancelled (see sections 222 and 223). However, there is no requirement for a register to be kept of disqualified practitioners.

Where a practitioner the subject of a complaint is no longer registered, the Tribunal can impose a disqualification order against the practitioner (if it would have imposed a cancellation order had the practitioner been registered). In NSW, a disqualification order applies until a “reinstatement order” is made by the Tribunal under s163B. If a reinstatement order is made, the practitioner can then, and only then, apply to the relevant National Board for registration.

The only material difference between a disqualification order and a cancellation of a practitioner’s registration is that in the former, the practitioner was not registered at the time of making the order.

As such, the Ministry’s preliminary view is that there is no good reason for the National Board not to maintain a public register of practitioners the subject of a disqualification order. Indeed, it would seem to be in the public interest for members of the public to be

³⁷ See s70 of the now repealed Medical Practice Act 2008

able to check if a practitioner is the subject of a disqualification order, particularly if the practitioner is providing health services that are not regulated under the National Law.

That said, it is noted however that the register provisions in sections 222 and 223 are national consistent provisions and therefore any changes to these sections would require changes to the National Law. Alternatively, NSW could establish a new NSW specific provision that required the National Board to keep a register of practitioners subject to a disqualification order in NSW. However, before NSW decided to establish a specific provision relating to the establishment or registers, issues relating to consistency with other jurisdictions would need to be properly considered.

Issues for consideration?

34) Should the Health Practitioner Regulation National Law (NSW) be amended to require the National Board to keep a public register of disqualified practitioners?

3.11 Structure and content of Part 8 and miscellaneous changes

A number of preliminary submissions received by the Ministry outlined concerns regarding the general structure of Part 8 of the Health Practitioner Regulation National Law (NSW).

It has been argued that Part 8 should be reviewed to ensure consistency of language, effect and intent of similar provisions, particular appeal rights. The need to ensure consistency with the Civil and Administrative Tribunal Act 2013 has also been raised.

The Ministry considers that there is some merit in these suggestions.

However, it is also noted that some of the differences in language and the effect and intent of the provisions relate to the difference processes that apply to the different professions, for example, PSCs vs Councils inquiries. As such, the nature and extent of possible changes will depend in part on what substantive changes flow on from the matters outlined earlier in this paper. That said, the Ministry is conscious of the need for Part 8 to be drafted in such a way that is precise, flows logically, clearly drafted and easy to use. Therefore, the Ministry will review the overall structure of Part 8 both now and in light of submissions received on this Discussion Paper to and seek to make any necessary changes to the structure of Part 8.

In addition, there are a number of minor changes the Ministry is proposing to make to the NSW specific provisions which are set out in Appendix A. These changes are not intended to represent a major policy change, but instead to bring the legislation up to date and make overall tidy ups to the legislation.

Issues for consideration?

35) What changes should be made to Part 8 to make it more user friendly?

36) Should the minor amendments set out in Appendix A be made?

3.11 Pharmacy Council – Pharmacy Premises Licensing

Schedule 5F of the Health Practitioner Regulation National Law (NSW) sets out various provisions relating to pharmacies, in particular setting out licensing requirements in relation to pharmacy businesses, being:

- Provisions limiting, except in limited circumstances, a person other than a pharmacist from having a pecuniary interest in a pharmacy business and requiring the Pharmacy Council to approve registration of a holder of pecuniary interest in a pharmacy businesses; and
- Provisions establishing a licensing regime for pharmacy business premises. Under these provisions, premises can only operate as a pharmacy business if the Pharmacy Council has approved the premises as a pharmacy premises (and all pecuniary interests in the business are in the Register of Pharmacies kept by the Council).

In relation to pecuniary interests, a person who holds a pecuniary interest in a pharmacy must submit annual returns to the Pharmacy Council specifying the interest they hold and the basis of their entitlement to hold the interest.

In respect of the pharmacy premises licensing provisions, the Pharmacy Council must not approve an premises to operate as a pharmacy premises that:

- Fail to comply with a standard prescribed for the premises by the NSW Regulations or
- Are within, or partly within, or adjacent or connected to, a supermarket and that the public can directly access from within the premises of the supermarket.

An application fee must be paid, which is currently around \$841. There are also annual licence renewal fees of \$341 and fees to record changes of ownership (currently around \$525 with higher fees for corporate arrangements).

The licensing of a pharmacy business helps to protect the public by ensuring that there is appropriate oversight by the Pharmacy Council of pharmacy businesses and ensures that the Council has the means to enforce standards operating in those premises as propriety interests must be held by pharmacists. However, it can be argued that the pharmacy licensing provisions are anticompetitive.

The Independent Pricing and Regulatory Tribunal (IPART) released its draft report from its Review of Licensing Rationale and Design.³⁸ The IPART draft report identified the Top 32

³⁸

http://www.ipart.nsw.gov.au/Home/Industries/Regulation_Review/Reviews/Licence_Design/Licence_Rationale_and_Design/22_May_2014_-_Draft_Report/Draft_Report_-_Reforming_licensing_in_NSW_-_Review_of_licence_rationale_and_design_-_October_2013

licences by regulatory burden and recommended that these licences be reviewed against a new Licensing Framework and Licensing Guide³⁹. This included the Pharmacy Registration and Renewal licence. Those aspects of pharmacy licensing that were identified by IPART as providing scope for reform include:

- Duration – Registration is currently only for 1 year, there may be potential for longer periods;
- Review process – Although the licencing arrangements have been reviewed in the last 5 years (when the National Law was adopted), no public consultation occurred on the issue and the scope of the review was limited;
- Fee setting – Although fee setting has been reviewed in the last 2 years, the fee setting could be improved;
- Compliance – blanket inspections and targeted inspections are covered. There may be scope to reduce compliance burden in respect of inspections; and
- Administration – There may be scope for more online services and/or a simplified process for renewal for licences with good track record of compliance.

More broadly, consideration also needs to be given to Best Practice Licensing Framework⁴⁰ and Licensing Guide⁴¹. The Framework and Guide seek to ensure that licenses are only imposed on the community when necessary and that licenses do not inappropriately stifle competition or increase costs and that licenses are appropriately designed and implemented.

The Ministry considers that there is a need to license pharmacy premises as it ensures the appropriate degree of oversight necessary for public protection. That is, the licensing of pharmacy premises ensures the appropriate safe handling, storage and dispensing of medications and that therefore there should the pharmacy licenses should continue.

However, the Ministry will consider whether amendments might need to be made to streamline the provisions and lessen regulatory burden where possible, and weigh these against other public policy considerations – including public health and safety.

³⁹ The Framework and Guide sets out a four stage model for consideration of the appropriateness of a licence option including whether it is (1) appropriate, (2) well designed, (3) effectively and efficiently administered, and (4) the best response.

⁴⁰ See

http://www.ipart.nsw.gov.au/Home/Industries/Regulation_Review/Reviews/Licence_Design/Licence_Rationale_and_Design/22_May_2014_-_Consultants_final_licensing_framework/PWC_-_A_best_practice_approach_to_licensing_schemes_-_Conceptual_Framework_-_March_2013

⁴¹

http://www.ipart.nsw.gov.au/Home/Industries/Regulation_Review/Reviews/Licence_Design/Licence_Rationale_and_Design/22_May_2014_-_Consultants_final_licensing_guide/PWC_-_A_best_practice_approach_to_licensing_schemes_-_Guidance_Material_-_March_2013

In relation to fees, currently, the Pharmacy Council sets the fees and there is no requirement for government or public oversight. The Ministry is considering whether amendments should be made to the Health Practitioner Regulation National Law (NSW) to instead require fees be prescribed in the Regulations. This would ensure that:

- the better regulation principles apply when making any changes, including fee increases, to the Regulation; and
- the Regulation, and the fees provisions, would be subject to the staged repeal process for Regulations and so would be reviewed periodically.

The Ministry would also like to hear submissions about what other changes could be made to streamline the pharmacy provisions so as to lessen regulatory burden, while still maintaining public safety. In particular, the Ministry would like to hear if there are changes that can be made to the administration of the licence provisions, such as a simplified system for applications and renewals and a better targeted approach to compliance.

More broadly, the Ministry is interested in hearing submission on whether the current terminology and definitions, such as “pharmacy business” and “pecuniary interest” used in Schedule 5F of the Health Practitioner Regulation National Law (NSW), are appropriate for today’s pharmacy businesses and whether the current protections are appropriate.

Issues for consideration?

- 37) Should the Health Practitioner Regulation National Law (NSW) be amended to require the fees in relation to pharmacy licences and registration to be set out in the Regulation?
- 38) What other changes can be made to administration of the licence provisions, such as a simplified system for applications and renewals and a better targeted approach to compliance, so as to lessen regulatory burden while still maintaining public safety.
- 39) Is the current terminology and definitions used in Schedule 5F of the Health Practitioner Regulation National Law (NSW) appropriate for today’s pharmacy businesses?
- 40) Are the current protections on pharmacy businesses appropriate?

4. Conclusion

The NSW specific provisions of the National Law are important legislative provisions that set out complaints handling provisions relating to registered health professionals. In the Ministry’s view while overall the objectives of the National Law remain valid, it is important to ensure that the legislative provisions which support the objectives remain up to date and appropriate so as to protect the public, ensure natural justice for practitioners and allow the complaints handling mechanisms operate in a cost effective manner.

Appendix A – Proposed Minor changes to the NSW specific provisions

Sections/Issue	Proposed change	Rationale
Sections 148E (general power of Council), 149A (general powers of Tribunal) and 150 (suspension or conditions of registration to protect public)	That s148E, s149A and s150 be amended to ensure a consistency of language relating to the power to impose conditions on a practitioner’s registration and the power to make other orders.	Under all these sections, there is a power to impose conditions on a practitioner’s registration and a power to make other orders (eg the practitioner to undergo counselling). The language used is not, but should be, consistent. The lack of consistency can lead to confusion (see for example Health Care Complaints Commission v Perceval [2014] NSWCATOD 38).
Jurisdiction of the Tribunal	Amendments to clarify the jurisdiction of the Tribunal in relation to matters under s145D of the Health Practitioner Regulation National Law is the general jurisdiction.	Under the Civil and Administrative Tribunal Act, the Tribunal’s jurisdiction is either general, administrative review, appeal (external or internal) or enforcement jurisdiction. Sections 145D of the Health Practitioner Regulation National Law (NSW) does not specify what the jurisdiction of the Tribunal when matters are referred to it. As hearings of matters under s145D are not in the appeals jurisdiction, the legislation should specify that it is in the general jurisdiction.
Section 146D (PSC can recommend suspension or cancellation)	An amendment to section 146D(1) to allow a PSC to recommend suspension or cancellation if satisfied that the practitioner does not have sufficient physical <i>or</i> mental capacity to practice the practitioner’s profession.	Under s146D(1), for a PSC to recommend suspension or cancellation, the PSC must be satisfied that the practitioner does not have sufficient physical <i>and</i> mental capacity to practice the practitioner’s profession. The Ministry considers that if a practitioner does not have

		<p>sufficient physical or mental capacity, either should be enough for the PSC to make a recommendation to suspend or cancel the practitioner's registration.</p>
<p>Interlocutory orders of the Tribunal – made by single List Manager member</p>	<p>An amendment to Part 8 to allow the Tribunal, constituted by a single member of the Tribunal who is the List Manager, to make interlocutory and ancillary orders in line with the definition of interlocutory and ancillary orders under the Civil and Administrative Tribunal Act</p>	<p>Interlocutory decisions are defined in s4 of the Civil and Administrative Tribunal Act as:</p> <ul style="list-style-type: none"> (a) the granting of a stay or adjournment, (b) the prohibition or restriction of the disclosure, broadcast or publication of matters, (c) the issue of a summons, (d) the extension of time for any matter (including for the lodgment of an application or appeal), (e) an evidential matter, (f) the disqualification of any member, (g) the joinder or misjoinder of a party to proceedings, (h) the summary dismissal of proceedings, (i) any other interlocutory issue before the Tribunal. <p>An ancillary matter is defined in s4 as a decision that is "preliminary to, or consequential on, a decision determining proceedings, including:</p> <ul style="list-style-type: none"> (a) a decision concerning whether the Tribunal has jurisdiction to deal with a matter, and

		<p>(b) a decision concerning the awarding of costs in proceedings.”</p> <p>Allowing interlocutory and ancillary decisions to be made by the List Manager would save time and money.</p>
Schedule 5D clause 13 – Costs	Schedule 5D clause 13 be amended to allow the Tribunal, when making a costs order, to order that costs be assessed under the Legal Profession Act 2004	There is currently no express power to allow the Tribunal, when making a costs order, to order that costs be assessed. Such a power would avoid the costs and time in the Tribunal acting as an “assessing officer”.
Power of single member of the Tribunal to hear an application for a withdrawal of a complaint	That the Health Practitioner Regulation National Law (NSW) be amended to allow the List Manager to hear and determine an application to withdraw a complaint.	Allowing a single member to hear and determine a complaint would save costs and time.
PSC hearings when one member becomes available before an inquiry is completed or a decision is made	Amend Division 11 of Part 8 so that in the event a one of the members of a PSC (other than the presiding members) vacates office or becomes unavailable before an inquiry is completed or a decision is made, the inquiry may continue and determination be made by the remaining members.	The ability to allow a PSC inquiry to continue if one member, other than the presiding member, becomes unavailable, will save unnecessary delay by preventing adjournments.
Appeal rights under Part 8: ss175, 158, 159, 159A, 160	<p>These sections should be amended to use a consistent language to provide that:</p> <ul style="list-style-type: none"> • an appeal is an external appeal to the Tribunal and • that the appeal is to be dealt with by way of a rehearing of the matter with fresh evidence 	These sections all give a right to appeal decisions made by various bodies, such as a National Board, PSC or a Council, to the Tribunal in the external appeals jurisdiction (the external appeals jurisdiction is an appeal right to the Tribunal from a body external to the Tribunal). Most, but not all of these sections

	being able to be given.	make clear that the Tribunal can hear the matter <i>de novo</i> (that is, a new hearing is held with fresh evidence able to be submitted). However, there is an inconsistency in the language used in these provisions. The language used should be consistent to ensure clarity and consistency in appeal rights.
Part 1 of Schedule 5C – membership of certain Councils	Part 1 of Schedule 5C should be deleted	Part 1 of Schedule 5C sets out the membership of certain Councils. However, this Part is redundant as the membership of the Councils are now set out in the Health Practitioner Regulation (New South Wales) Regulation 2010 in accordance with s41E