NSW HEALTH

Report of the Review of the Optometrists Act 1930

December 1999

EXECUTIVE SUMMARY AND SUMMARY OF RECOMMENDATIONS IV

1. INTRODUCTION 1

1.1 BACKGROUND TO THE REVIEW 1
1.2 THE CURRENT REVIEW 1
1.3 THE FINAL REPORT 2

2. THE REGULATION OF OPTOMETRISTS AND OTHER SERVICE PROVIDERS 3

2.1 INTRODUCTION - THE PROVISION OF EYE CARE SERVICES 3
2.2 THE OPTOMETRISTS ACT 1930 4
2.3 OTHER LEGISLATION 7
2.4 THE ROLE OF PROFESSIONAL ASSOCIATIONS 7
2.5 OTHER SERVICE PROVIDERS 7
2.6 THE REGULATION OF OPTOMETRY IN OTHER JURISDICTIONS 7
2.7 IMPACT OF THE LEGISLATION ON COMPETITION 9
2.8 OTHER MARKET RESTRICTIONS: ACCESS TO MEDICARE REBATES 10

3. THE OBJECTIVES OF LEGISLATION REGULATING OPTOMETRY 11

3.1 INTRODUCTION 11
3.2 SUBMISSIONS 12
3.3 OBJECTIVES OF THE ACT - PROTECTION OF CONSUMERS FROM HARM 14
3.4 OBJECTIVES OF THE ACT – FACILITATING OPTOMETRISTS' ROLE AS PROVIDERS OF PRIMARY EYE CARE 16
3.5 CONCLUSION 16

4. REGISTRATION OF OPTOMETRISTS, COMPETITION AND REGULATORY OPTIONS 18

4.1 INTRODUCTION 18
4.2 REGULATORY OPTIONS 18
4.3 SUBMISSIONS ON REGULATORY OPTIONS 19
4.4 RESULTS OF THE ECONOMIC ANALYSIS BY ACIL CONSULTING 22
4.5 THE DEPARTMENT'S PREFERRED POSITION 23
4.5.1 Options 1 to 3 23
4.5.2 Option 4 - Title regulation 24
4.5.3 Options 5 – 7: Is there a case for restrictions on the practice of optometry? 25
4.6 CORE PRACTICE RESTRICTIONS – EXEMPTIONS FOR PERSONS ACTING UNDER THE SUPERVISION OF A REGISTERED OPTOMETRIST OR MEDICAL PRACTITIONER 30
4.7 CORE PRACTICE RESTRICTIONS – SHOULD ORTHOPTISTS BE EXEMPT? 31
4.8 SHOULD OPTICAL DISPENSERS HAVE AN EXEMPTION? 34

5. ACCESS TO THERAPEUTIC DRUGS 36

5.1 INTRODUCTION 36
5.2 THE DEPARTMENT'S DRAFT POSITION ON ACCESS TO THERAPEUTICS 36
5.3 SUBMISSIONS 37
5.4 CONCLUSIONS 39

6. RESTRICTIONS ON OWNERSHIP OF PRACTICES 41

6.1 INTRODUCTION 41
6.2 THE POTENTIAL IMPACT OF OWNERSHIP RESTRICTIONS 42
6.3 RESULTS OF THE ECONOMIC ANALYSIS CONDUCTED BY ACIL CONSULTING 45
6.4 SUBMISSIONS 45
6.5 THE DEPARTMENT'S POSITION 48
6.5.1 Evidence concerning the risks of harm to consumers from ownership of commercial practices by non-optometrists 48
6.5.2 Impact on increased competition on rural communities 50
6.5.3 Evidence concerning the costs of the current restrictions 51
6.5.4 Achieving the objectives of the legislation 51

7. OTHER CONSUMER ISSUES 55

7.1 MANDATORY RELEASE OF PRESCRIPTIONS 55
7.2 ADVERTISING BY REGISTERED OPTOMETRISTS 56

8. REGISTRATION CRITERIA FOR OPTOMETRISTS 59

8.1 INTRODUCTION 59
8.2 GOOD CHARACTER 59
8.3 APPLICANTS MUST BE TWENTY-ONE YEARS OF AGE OR ABOVE 60
8.4 ASSESSMENT OF COMPETENCE AT INITIAL REGISTRATION - QUALIFICATIONS. 60
8.4.1 Introduction 60
8.4.2 Submissions 61
8.4.3 Are current training requirements unnecessarily restricting entry to the profession? 62
8.4.4 Demonstrated professional competence 63
8.4.5 Recognition of courses 64
8.4.6 The Optometry Council (TOC) 64
8.4.7 Overseas applicants 65
8.5 REGISTRATION - COMPETENCE TO PRACTISE 65
8.5.1 Skill 65
8.5.2 Recency of practice 66
8.5.3 Physical and mental capacity 67
8.5.4 English language 67
8.6 REFUSAL OF REGISTRATION - DISCIPLINARY ACTION IN A FOREIGN JURISDICTION 68
8.7 CRIMINAL CONVICTIONS 68
8.8 DECLARATIONS BY APPLICANTS AT THE TIME OF REGISTRATION 70
8.9 REGISTRATION CATEGORIES 70

9. CONTINUING REGISTRATION 72

9.1 INTRODUCTION 72
9.2 ANNUAL COMPETENCY ASSESSMENT 72
9.3 MANDATORY CONTINUING EDUCATION 72
9.4 MANDATORY DISCLOSURE OF INFORMATION TO THE BOARD 73
9.4.1 Charges and convictions for offences 73
9.4.2 Continuing education 74
9.4.3 Complaints 74
9.4.4 Complaints/disciplinary action in other jurisdictions 74
9.4.5 Serious illness related to physical and mental capacity 74
9.5 CRIMINAL CONVICTIONS 75

10. COMPLAINTS AND DISCIPLINARY STRUCTURES 77

10.1 INTRODUCTION 77
10.2 THE NEED FOR A COMPLAINTS AND DISCIPLINARY SYSTEM 77
10.3 GROUNDS FOR COMPLAINTS AND DISCIPLINARY ACTION 78
10.3.1 Statutory definition of unsatisfactory professional conduct and professional misconduct 78
10.3.2 Character, physical and mental capacity, addiction to drugs or alcohol 79
10.3.3 Criminal conviction 79
10.3.4 Establishment of a Complaints Assessment Committee 80
10.4 CONTENT OF THE DEFINITIONS OF UNSATISFACTORY PROFESSIONAL CONDUCT AND PROFESSIONAL MISCONDUCT 80
10.4.1 Lack of adequate knowledge, skill, judgement or care 81
10.4.2 A contravention of the Act or Regulations 81
10.4.3 Failure to comply with a condition on registration, or an order or direction of the Board or a disciplinary body 81
10.4.4 A practitioner holding him or herself out as having qualifications other than those recorded in the Reguister 81
10.4.5 Any other improper or unethical conduct relating to the practice of the profession 81
10.4.6 Failure to respond to a Board request for information without reasonable excuse 82
10.4.7 Over-servicing 82
10.4.8 Failure to disclose a conflict of interest 82
10.5 CODES OF CONDUCT 83
10.6 DEALING WITH COMPLAINTS 85
10.6.1 Disciplinary and other bodies 85
10.6.2 Submissions 85
10.6.3 Option 1 - PSC/Tribunal Structure 86

10.6.4 Option 2 - A system based on the Dental Care Assessment Committee ... 87
10.6.5 Role of the Health Care Complaints Commission ... 88
10.6.6 The Department's position ... 89
10.7 IMPAIRMENT ... 89
10.8 COMPLAINTS HANDLING PROCEDURES ... 90
10.9 POWERS OF DISCIPLINARY BODIES FOR THE CONDUCT OF HEARINGS ... 91
10.9.1 General powers ... 91
10.9.2 Power to award costs ... 92
10.9.3 Access of the public to disciplinary proceedings ... 92
10.10 ACTION AGAINST PRACTITIONERS WHO CEASE TO BE REGISTERED ... 93

11. ADMINISTRATION OF THE OPTOMETRISTS ACT AND OTHER ISSUES ... 94

11.1 COMPOSITION OF THE BOARD ... 94
11.1.1 Increase in the size of the Board ... 94
11.1.2 Optometric representation ... 94
11.1.3 Medical practitioner ... 95
11.1.4 Optical dispenser representation ... 95
11.1.5 Community representation ... 96
11.1.6 President and Deputy President ... 96
11.2 TENURE OF BOARD MEMBERS ... 96
11.3 SUB-COMMITTEES ... 97
11.4 EDUCATION AND RESEARCH ACCOUNT ... 97
11.5 OTHER ISSUES ... 98

APPENDIX A – TERMS OF REFERENCE ... 99

APPENDIX B – LIST OF SUBMISSIONS TO THE REVIEW ... 100

APPENDIX C – ECONOMIC EVALUATION BY ACIL CONSULTING ... 101

APPENDIX D SUMMARY OF LEGISLATION REGULATING OPTOMETRY IN OTHER JURISDICTIONS ... 107

APPENDIX E COMPLAINTS RELATING TO OPTOMETRISTS ... 108

EXECUTIVE SUMMARY AND SUMMARY OF RECOMMENDATIONS

1 - Introduction

The current NSW Optometrists Act was enacted in 1930. The Act creates the Board of Optometrical Registration and provides that only those people who possess appropriate tertiary qualifications and who are of good character may register with the Board and engage in the "practice of optometry" as defined in the Act.

The Act has been under review for a number of years and an exposure draft Bill was released in 1993. The current review has given particular attention to the Council of Australian Governments (COAG) Competition Principles Agreement, which commits Commonwealth, State and Territory governments to consider the potential anti-competitive effect of all legislation.

To facilitate the review process, the Department prepared an Issues Paper which was released for public comment in July 1998. The Department has prepared this Report for consideration by the Minister for Health and the NSW Government in satisfaction of the review requirements under the Agreement. While this report is directed primarily at addressing the issues arising by way of the Competition Principles Agreement, other matters considered during the review are identified and addressed where appropriate.

2. The Regulation of Optometrists and Other Service Providers

Optometrists provide a range of eye examination and vision correction services to the public. These services include the examination of the eyes and measurement of their functions and powers; remedying and relieving an abnormality or defect of sight by way of an optical appliance or orthoptic treatment; and the prescribing, dispensing and fitting of spectacles and contact lenses. In total the eye care market in NSW was worth in excess of $185 million in 1996/7, of which optometrists are estimated to have contributed $80 million. There are a number of professionals other than optometrists who provide eye care services including ophthalmologists, general practitioners, orthoptists, optical dispensers and various other service providers.

The principle of the Competition Principles Agreement guiding the current review is that the costs arising from the restrictions contained in legislation such as the Optometrists Act 1930 should be outweighed by the benefits they produce, and the objective of the legislation can only be met by restricting competition. The provisions of the Act requiring review are:

(i) People who are not registered as optometrists, or exempted under the Act, cannot practise optometry as defined by the Act or use the term 'optometrist'.
(ii) People who are not registered as optometrists, firms and corporations cannot own or operate an optometry practice.
(iii) Optometrists are not permitted to use therapeutic drugs in the practice of optometry or assume titles implying medical qualifications.
(iv) Orthoptists are restricted to providing orthoptic treatment under the direction of a registered medical practitioner or optometrist.
(v) Optical dispensers are restricted in the services that they may provide.

3. Objectives of Legislation Regulating Optometry

To comply with the COAG Competition Principles Agreement, the NSW Government is required to identify the objectives of the *Optometrists Act 1930* and to consider whether there is a rationale for achieving these objectives through legislation. If it is established that there is a rationale for legislative intervention, the precise form of intervention, that is registration by title or alternative means, needs to be considered.

Protection of consumers from harm is consistently identified in submissions as the principal objective of the legislation. The Department supports this view. While there is little clear quantitative evidence that establishes an underlying rationale for this objective there is substantial qualitative evidence to justify intervention. The problem, which faces those seeking to use optometric services, is the imbalance of information between practitioners, both optometric and other, and patients. The Board should be required to exercise its functions in a manner consistent with the objectives.

Recommendation 1 – Objective

It is recommended that the Act have the objective of minimising the risks of serious harm or injury to those seeking to use optometric services, with an express requirement for the Board to exercise its functions in a manner consistent with the objectives.

4. Registration of Optometrists, Competition and Regulatory Options

Compared to other health professional registration legislation, the Optometrists Act 1930 is highly restrictive in that it restricts the use of ‘title’ and ‘practice’. The review principle under the Competition Principles Agreement requires the Department to consider options for the Regulation of optometrists, from no regulation to the status quo.

Option 1 — **No regulation or self-regulation by professional associations** – Any person could engage in the practice of optometry and describe themselves as an optometrist. The conduct of individuals would be subject to the Fair Trading Act 1982 and the Trade Practices Act 1974 (Cth). Complaints could be made under the Health Care Complaints Act 1993, although there would be no statutory mechanism for disciplining practitioners. Nonetheless professional associations could undertake this task within the bounds of trade practices legislation and the general law. This option has been considered in Chapter 3.

Option 2 — **Co-regulation** – This option is broadly similar to Option 1 except that Government would intervene, either legislatively or administratively to accredit professional associations which effectively discipline their members. Government and/or professional associations would promote the benefits of dealing with a member of an accredited association. Those that are not members of associations could, however, continue to practise.

Option 3 — **Voluntary accreditation by a government or statutory body** – An accreditation body, similar to the current Board, would accredit practitioners as competent to practise and discipline members. Optometric practitioners and unregistered persons would not be required to be accredited to practise or use the title

optometrist, although they would be entitled to hold themselves out as accredited by the Board.

Option 4 **Title regulation only –** This is essentially the same as Option 3, except that accredited/registered practitioners would be entitled to use the title "optometrist".

Option 5 **Title and core practice restrictions** – This is the same as Option 4, except that certain core practices which have been identified as carrying significant risks carried out by unregistered persons, would be restricted to those that are registered under the Act. A variation on this option would be to grant exemptions to non-optometrists where they can demonstrate that they have sufficient competence to provide the restricted practice.

Option 6 **Title and whole of practice with exemptions –** As for option 5 but with exemptions for appropriately qualified groups.

Option 7 **Title and whole of practice restrictions** – This is the current system as outlined in Chapter 2 and summarised at 4.1. Legislation would attempt to define all of the practices that comprise the practice of optometry and restrict them to registered optometrists.

ACIL Consulting conducted an economic appraisal of the options for regulation of the optometric profession pertaining to registration, restrictions on practice and ownership restrictions. ACIL concluded in its Report that the existing practice restrictions should be retained, with an exemption for orthoptists who upgrade their qualifications (Option 6). However, ACIL suggests that the lack of available data and the indicative nature of the assessment procedures used should temper this conclusion.

After considering this Report and the submissions received, the Department has reached a different conclusion. While a regulatory system based on title restrictions is supported, limited evidence has been presented to suggest that practice, particularly whole of practice, restrictions provide a greater level of protection than other forms of regulation such as a title restriction alone. It is the Department's view that "whole of practice" restrictions fail to recognise the changing roles of professional practice and have the potential to stifle development of new services by both optometrists and potential competitors and there is a need to ensure that such restriction does not unjustifiably restrict competition. It is the Department's view that this can be achieved by:

- Restricting use of the title optometrist.
- Restricting only certain identified 'dangerous' core-practices (rather than the whole of practice) where there is evidence to support these restrictions. In the current review, the core practices have been identified as prescribing of glasses and fitting of contact lenses.
- Include a provision that enables other professional groups to be exempt by regulation in circumstances where they can establish they have sufficient competence.

At this time the Department supports a limited range of exemptions for persons acting under supervision of a registered optometrist or medical practitioner, and for orthoptists who provide treatment on referral from a registered medical practitioner. A wider exemption for orthoptists to engage in the core practices without requiring patients to be referred will be considered during development of regulations.

Recommendation 2 – Registration by Title

It is recommended that the Act:

- Provide for the establishment of a register of optometrists.
- Restrict use of the title 'optometrist' and other titles prescribed by regulation.

Recommendation 3 – "Optician"

It is recommended that in developing regulations under the Act, the Minister consider whether the title 'optician' should continue to be restricted by regulation.

Recommendation 4 – Core Practice Restrictions

It is recommended that the Public Health Act 1991 be amended to provide that only registered optometrists, medical practitioners and others exempted by that Act or regulations made under the Act may engage in the practice of prescribing glasses and the fitting of contact lenses.

Recommendation 5 – Exemption for Persons Acting Under Supervision

It is recommended that the Public Health Act provide an exemption from the core practices for individuals acting under the supervision or control of a registered optometrist or medical practitioner.

Recommendation 6 – Exemptions for Orthoptists

It is recommended that:

(a) Orthoptists be exempt from the core practices identified in recommendation 4 where a registered medical practitioner refers the patient to them.

(b) In developing Regulations under the Public Health Act 1991, consideration be given to including an exemption for orthoptists to enable them to treat patients in their own right.

5. Access To Therapeutic and Diagnostic Drugs

The current Optometrists Act permits optometrists to use diagnostic drugs in the course of their practice where they hold a certificate from the Board. However, optometrists are not permitted to use drugs for any therapeutic purpose. The introduction of new legislation to regulate the optometry profession has been impeded for a number of years by an inter-professional dispute over whether optometrists should be given access to therapeutic drugs.

Optometrists argue that they should have access to a limited range of ocular therapeutics to facilitate an expanded primary eye care role. The medical profession, particularly ophthalmologists, have strongly resisted such moves arguing that optometrists are inadequately trained to carry out this role.

The Clinical Issues Working Party established by the Minister specifically considered whether optometrists should have access to drugs for the purposes of treating minor anterior eye

conditions. Although consensus on the issue of whether optometrist's current training is adequate was not reached, a number of recommendations of principle were made. After considering the Working Party's report the Department in the Issues Paper put forward a proposal to grant access to a limited range of therapeutic drugs.

After considering submissions, the Department remains of the view that optometrists should be entitled to prescribe or administer appropriate S4 therapeutic agents if it can be demonstrated training is of an appropriate standard. To be able to do this optometrists will need to hold additional post-graduate training prescribed by the Regulation. This has the potential to deliver substantial benefits to the community in terms of improved access and reduced inconvenience.

Access to therapeutic S2 and S3 therapeutic drugs will also be permitted (without the need for additional post-graduate training) and the current range of diagnostic drugs available to optometrists will not be restricted.

Recommendation 7 – Access to Drugs

It is recommended that:

(i) The restrictions on the use of drugs in the Optometrists Act 1930 be removed.

(ii) Optometrists be permitted to use diagnostic drugs (S2, S3 and S4) and therapeutic S2 and S3 drugs prescribed in Appendix E of the Poisons and Therapeutic Goods Regulations in the course of their practice unless restricted from doing so as a condition of registration.

(iii) The Poisons and Therapeutic Goods Act be amended to enable optometrists with prescribed post-graduate qualifications to use and prescribe those therapeutic topical S4 preparations prescribed under the Poisons and Therapeutic Goods Regulation 1996.

(iv) Those practitioners entitled to use and prescribe therapeutic agents must, as a condition of the entitlement, comply with clinical practice guidelines (if any) approved by the Minister.

(v) The Minister consult with the Optometric Association of Australia, the Board of Optometrical Registration, the Royal Australian College of Ophthalmologists and other appropriate bodies in prescribing training and therapeutic substances for use by optometrists who may prescribe and use therapeutics.

6. Restrictions on Ownership of Practices

Section 35 of the Optometrists Act provides:

> *"Except as provided by subsection (2), or with the approval of the Minister in writing, no firm or company or other person not being a registered optometrist shall carry on the business of the practice of optometry."*

The approval of new persons operating such businesses by the Minister was prohibited outright from 1969. The Issues Paper noted that such restrictions have the potential to restrict competition, resulting in higher prices for consumers and a decline in the quality of services.

Submissions were sought as to whether these restrictions should be retained, and if so, whether

their retention is consistent with the Competition Principles Agreement. In order for the current restrictions to be retained it must be established that the benefits arising from the restrictions as a whole outweigh the costs, and that the objectives of the legislation (maintenance of public health and safety) can only be achieved by restricting competition.

Substantial material has been presented to the Department by the optometric profession suggesting there may be risks to consumers if the ownership restrictions were removed. It is the Department's view that this material provides only limited evidence to support the claim that non-optometrists may improperly seek to influence the conduct of optometric practices. While there are clearly some risks (although these are of low level significance), it is apparent that these risks are not isolated to non-optometrist owned practices and have also presented in optometrist owned practices.

The impact of deregulation on any community, particularly rural communities is a significant consideration for the Government. However, no evidence of substance has been presented to suggest that this has resulted in the withdrawal of services.

Again evidence concerning the costs of the current restrictions is limited. While the material from the United States suggests there is the potential for significant savings in both consultation fees and the cost of glasses, it is difficult to draw conclusions from this in the NSW market because of the existence of Medicare. There is however sufficient material to suggest that ownership restrictions do have some impact in terms of the price of goods and on the quality of services provided.

The Department has identified an alternative to ownership restrictions that will limit the impact on competition. It is the Department's view that these measures will eliminate the potential risks that arise where professional obligations are overridden by commercial considerations.

Recommendation 8 – Ownership of Optometric Practices

It is recommended that the prohibition on the conduct of the business of the practice of optometry by firms, companies or other unregistered persons be repealed.

Recommendation 9 – Offence of Improperly Influencing the Practice of Optometry

(a) It is recommended that legislation regulating the optometry profession prohibit a person or company from:

(i) directing a registered optometrist to provide a service of a kind that is excessive, unnecessary or not reasonably required for that person's well-being; or
(ii) directing or influencing a registered optometrist such that they engage in conduct that would constitute unsatisfactory professional conduct or professional misconduct.

(b) It is recommended that the legislation be amended to include a regulation making power to enable certain matters to be prima facie evidence of a breach of the prohibition contained in (a)(I).

(c) It is recommended that action under (a)(ii) against a person or company will only be allowed to proceed where the practitioner concerned has been found guilty of professional misconduct or unsatisfactory professional conduct during disciplinary proceedings.

(d) It is recommended that the legislation provide that where a company is convicted of an offence under 9(a), every director or person concerned with the management of the company is also guilty of an offence unless they had no knowledge of the offence and they exercised due diligence to prevent the contravention.

Recommendation 10 – Disqualification of Non-Optometric Service Providers

(a) It is recommended that the legislation provide that the Director-General may suspend or disqualify a company or a person who is a proprietor, trustee, beneficiary, director, major shareholder or is otherwise involved in carrying on the business of providing consulting optometric services from carrying on, or being involved in carrying on the business of providing optometric services (either generally or at specified premises) where:

(i) conviction for an offence contained in recommendation 9(a) has occurred; and
(ii) the Director-General is satisfied that the person or company is no longer fit and proper to carry on, or be involved in the carrying on, the business of providing optometric services.

(b) It is recommended that the legislation make provision to prevent the objectives of the suspension provisions from being thwarted by the adoption of business structures or through business restructuring designed to circumvent the operation of the exclusion provisions.

Recommendation 11 – Availability of Records

It is recommended that registered optometrists be permitted to obtain a copy of a patient's record from a previous employer with the consent in writing of the patient.

7. Other Consumer Issues

Mandatory release of prescriptions

The Department is of the view that a mandatory release requirement for glasses and contact lenses would be of substantial benefit for consumers and would facilitate competition between optometrists and other suppliers of appliances. It should be recognised that such provisions will impose costs on practitioners in terms of time and resources, but these are likely to be marginal when compared with the competitive benefits that will flow from the requirement. It is the Department's preferred position for this issue to be dealt with by way of regulation or through a code of professional conduct.

Recommendation 12 – Release of Prescriptions

It is recommended that the Act include a provision (either by way of Regulation or through a code of professional conduct) to require the automatic release of prescriptions for optical appliances (including contact lenses) by optometrists.

Advertising by registered optometrists

Advertising by registered optometrists is currently regulated by Clause 20 of the Optometrists Regulation 1995. The existing provisions reflect the misleading and deceptive conduct provisions of the Fair Trading Act (NSW) and the Trade Practices Act (Cth).

On balance the Department supports the retention of a regulation making power over advertising. While highly prescriptive advertising standards have in the past limited the flow of information to consumers, this is no longer the case. An opportunity to review the current standards set by regulation will arise when regulations under new legislation are developed.

The strongest argument against regulatory controls on advertising, that is the existing regulations duplicates generic Trade Practices legislation, has superficial merit. This argument ignores the fact that the effective regulation of advertising under generic legislation will depend upon the responsible regulatory body, the ACCC, taking appropriate enforcement action. The ACCC has recently advised the OAA (NSW) that it is necessarily selective in its enforcement action because it cannot pursue every breach of legislation. The retention of regulatory controls under optometric legislation will ensure that advertising can be acted upon swiftly, without relying on the resources of other enforcement agencies.

Recommendation 13 – Advertising

It is recommended that the Act include a provision to enable standards to be set (either by way of Regulation or through a code of professional conduct) for advertising by optometrists (and others entitled to provide optometric services).

8. Initial Registration Criteria for Optometrists

Section 19 of the Optometrists Act 1930 requires an applicant for registration as an optometrist to be of good character, twenty-one years of age or above and to pay the prescribed fee. The applicant must also hold one of the prescribed qualifications, which are set out earlier in Chapter 2.

Registration requirements are designed to achieve the objectives of the Act by ensuring that those practitioners that become registered will not cause harm to patients, or otherwise jeopardise the public interest. However, if entry level requirements are set artificially high, this may restrict the number of people able to seek registration as optometrists, with a resultant impact on competition. In some cases, registration requirements may not have any connection with securing the objectives of the Act, protection of the public from harm.

Submissions to the review strongly supported a requirement that applicants demonstrate good character, with some arguing that such a requirement only has a marginal impact on competition. Health professionals hold an important position of trust with their patients. A requirement for good character is essential to ensure that consumers are protected from harm in accordance with the Acts objectives.

The Issues Paper noted that an age limit serves to create another barrier to entry, and is in effect rendered inoperative by the Mutual Recognition Act. In addition, most practitioners would be 21 by the time they have completed the required training. Submissions overwhelmingly supported removal of this requirement.

Recommendation 14 – Character

It is recommended that the requirement that applicants for initial registration demonstrate that they are of good character be retained in the new Act.

Assessment of competence at initial registration - qualifications.

It is the Department's view that competency should principally be established by applicants through the completion of recognised qualifications. The Act specifically recognises courses from the University of NSW. For graduates of other courses, that course must be "recognised by the Board as furnishing sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of optometry in NSW". It is the Department's view that legislation regulating the optometry profession should provide a clear and transparent avenue through which courses can be accredited. It is therefore proposed that the Act be amended so that the Board can receive applications from educational institutions for accreditation with a right of appeal to the Administrative Decisions Tribunal. Courses will be assessed against criteria prescribed by regulation, such as competency standards.

The advent of mutual recognition legislation has highlighted the need for a national accreditation body to assess overseas qualifications and conduct examinations where appropriate. In establishing a national body, economies of scale are achieved that are not available to state based bodies. For these reasons, the Department supports establishment of a national examination and assessment body and supports the introduction of provisions in legislation to enable the accreditation procedures of an appropriate body to be recognised by the registration board. However, suggestions that the newly established Optometry Council should obtain a statutory monopoly on the assessment of overseas qualifications and examination of overseas applicants are not supported.

Recommendation 15 – Assessment of Competence at the Time of Registration

It is recommended that the Act provide that an applicant will be entitled to registration where he/she has successfully completed:

(i) a qualification prescribed by the Regulations; or
(ii) a qualification that has been assessed by the Board as meeting the criteria prescribed by the Regulations; or
(iii) a qualification that has been approved by the Board, on the recommendation of another accreditation body; or
(iv) an examination arranged or approved by the Board.

Recommendation 16 – Accreditation of Courses

It is recommended that the Act enable educational or training institutions to apply to the Board to have qualifications assessed or approved in accordance with (ii) and (iii) as meeting the criteria prescribed by Regulation, with a right of appeal on the merits to the Administrative Decisions Tribunal.

Refusal of Registration

Although it is recognised that competence should be established primarily through satisfying the qualification requirements, there are significant benefits in including a power to refuse registration in over-riding circumstances where there is evidence available to the Board that an applicant does not have sufficient skill to practise in a safe and competent manner. In the absence of such a requirement, the applicant would need to be registered and then a complaint would have to be lodged immediately by the Board. Clearly, this is inefficient and not in the public interest. In light of the minimal impact on entry, (primarily because the Board would only be able to exercise such a

power following an inquiry), the Department is of the view that the benefits in terms of improved information for consumers are likely to outweigh any costs.

Recommendation 17 – Grounds for Refusing Registration or Imposing Conditions

(a) It is recommended that the Act provide that the Board may refuse registration or impose conditions, subject to a right of appeal to the Administrative Decisions Tribunal, where:

(i) a person does not have sufficient competence to practise as an optometrist, including lack of skill, physical or mental capacity (including addiction to drugs or alcohol) or lack of an adequate command of English;
(ii) the person has been convicted of an offence or has had an offence proved against them which renders them unfit in the public interest to practise as an optometrist;
(iii) a person has been the subject of disciplinary action in another jurisdiction (other than a jurisdiction to which mutual recognition applies).

(b) It is recommended that the Act provide that the Board may only refuse registration on the basis of lack of an adequate command of English after it has considered options that are less restrictive and is satisfied that these options will not provide for the protection from the risk of serious injury or harm.

Recommendation 18 – Inquiries into Registration Applications

It is recommended that the legislation provide that the Board may conduct an inquiry into such an application with similar powers to those which apply under the current Medical Practice Act 1992 following notification to the HCCC. The HCCC will be allowed to appear at the inquiry at the discretion of the Board.

Declarations by applicants at the time of registration

The Board's ability to give appropriate consideration to applications is limited by its ability to obtain information. To assist the Board in obtaining relevant information, the Department supports the introduction of 'declaration' requirements on new applicants for registration.

Recommendation 19 – Declarations by applicants for Registration

It is recommended that the Act provide that applicants for initial registration must disclose:
- Criminal convictions and offences proved but dismissed under s.556A of the Crimes Act; and
- Charges for serious sex and violence offences where the allegations relate to conduct that occurred in the course of practice.

Registration categories

The current Act provides that the Board may grant full registration or provisional registration only. Expanded registration categories, including temporary registration and conditional registration, will give the Board greater flexibility at the time of registration.

Submissions were sought on the question of whether conditionally registered people should be prevented from holding themselves out as full registrants or should be required to disclose the conditions on their registration. The Department considers it is important that consumers are made aware that registration is subject to conditions. Therefore such practitioners should only be permitted

to describe themselves as conditional registrants.

The Board has recommended that the Act provide that students must be registered. However, no evidence has been provided to the current review of significant problems arising from impairment among students of optometry, or of risks to public health and safety presented by students.

Recommendation 20 – Categories of Registration

It is recommended that the Act provide for the following classes of registration:

(i) full registration;
(ii) provisional registration;
(iii) temporary registration for the purposes of carrying out education, research or any other activity which is in the public interest;
(iv) conditional registration for practitioners that have had conditions imposed on their registration either at the time of registration or following disciplinary action.

Recommendation 21 – Conditional Registrants

It is recommended that the Act provide that conditional registrants may only describe themselves as conditionally registered.

9. Continuing Registration

The current Optometrists Act 1930 seeks to provide patients with information about the ongoing competence of practitioners. This is currently done through initial registration criteria, the complaints/disciplinary system and the practitioner's professional obligations to maintain their skills at an appropriate level. The Issues Paper sought submissions on possible strategies that might be introduced to encourage professionals to take a more active role in maintaining their professional standards. The following matters were identified for consideration:

- Annual competency assessment;
- Mandatory continuing education;
- Provision of information by applicants for renewal of registration;
- Recency of practice

On balance, the Department does not support the introduction of continuing competency assessment at this time on the basis that the complaints system is sufficient to monitor ongoing competence of optometric practitioners having regard to the general scope of their practice. Similarly, the Department is of the view that mandatory continuing education should not be made a requirement for re-registration because the professional association takes an active role in ensuring members maintain their competence, such a system would ensure that consumers have access to information, particularly for those practitioners that are not members of professional associations.

Recommendation 22 – Continuing Education

It is recommended that the Act provide that the Board may issue non-mandatory guidelines for continuing education.

Renewal of registration

In general, the Department supports a more comprehensive process for renewing registration to enable the Board to adequately assess whether a registered practitioner continues to be competent to practise and of good character. Further, in some cases, it may be necessary for an obligation to be imposed on a practitioner to notify certain information to the Board at times other than registration. In cases where serious deficiencies are identified, the Board can institute disciplinary action.

Recommendation 23 – Renewal of Registration

It is recommended that Act provide that applicants for renewal of registration be required to make declarations on:

- Criminal convictions (recorded and unrecorded);
- Charges for serious sex or violence offences where the allegations relate to conduct occurring in the course of practice;
- Significant illness for the purposes of identifying whether there may be issues of physical or mental capacity (including addiction);
- Continuing education activities.

Criminal convictions

The criminal justice system can provide information relevant to whether disciplinary action should be initiated against a practitioner. The Department has been considering all health professional registration Acts to ensure that they continue to reflect the high standards expected by the community by adequately addressing questions of character and criminal conviction. The Department has identified a number of strategies that would be of assistance in this regard.

A criminal charge per se would not constitute the basis for disciplinary action. Rather, the charge and the circumstances surrounding it can be relevant to a practitioner's overall ability to practise and to questions of character. It should be noted that under the Health Services Act employees and visiting practitioners appointed by a public health organisation who have been charged with or convicted of a serious sex or violence offence are under a positive obligation to report that information to the CEO of the organisation.

Recommendation 24 – Criminal Convictions

It is recommended that the Act provide for the following:

- Courts be required to notify the relevant registration board of any practitioners who are convicted of an offence (irrespective of whether it is recorded or not) unless it is an offence of a type that is not required to be notified to the Board concerned;
- Practitioners be required to notify the relevant registration board if they are convicted of an offence which is reportable by the courts; and
- Practitioners be required to notify the relevant registration board with in seven days if charged with a "serious sex or violence offence" where the allegations relate to conduct occurring in the course of practice.

10. Complaints and Disciplinary Structures

An effective complaints handling and disciplinary structure can be used to monitor and enforce practice and ethical standards in the profession and help to reduce the incidence of consumer dissatisfaction. In short it can enhance competition by improving the information available to consumers. However where disciplinary structures are used to restrain commercial activity, such as advertising, they may have an anti-competitive effect which is of little or no benefit to consumers. On balance, the Department supports retention of a complaints and disciplinary system.

Grounds for complaints and disciplinary action

The current Act does not set out the grounds for making complaints about registered optometrists, although in practice the Board receives complaints on a range of matters. The Department supports specifying in the Act the grounds upon which a complaint may be made.
In general the grounds for complaint should closely mirror the requirements for registration.

In addition, the Department supports codification of a two tiered definition of misconduct – “unsatisfactory professional conduct” and “professional misconduct”. Although the current ground in the Optometrists Act 1930 of "misconduct in a professional respect" provides a basis for disciplinary action, and has been given meaning by the common law, the failure to define this more clearly in the legislation creates considerable uncertainty for practitioners. Further it fails to adequately set out the community’s expectations of practitioners in relation to skill, judgement and competence.

Recommendation 25 – Grounds for Complaints

It is recommended that the Act provide that the Board may receive complaints and take disciplinary action where:

- A practitioner is guilty of unsatisfactory professional conduct (to deal with less serious matters) or professional misconduct (for more serious matters) as defined by the Act.
- A practitioner has been found guilty of an offence (including cases where the offence is found to be proved but no conviction is recorded) in circumstances that render the practitioner unfit, in the public interest, to practise.
- A practitioner has insufficient physical or mental capacity to practise.
- A practitioner is addicted to drugs or alcohol.
- A practitioner is not of good character.

Definition of unsatisfactory professional conduct and professional misconduct

In other professional registration legislation, "professional misconduct" is defined as "unsatisfactory professional conduct" of a sufficiently serious nature to justify the removal of the practitioners name from the register". The Department is of the view that “unsatisfactory professional conduct should be defined by reference to other similar health professional registration acts, namely:

- Lack of adequate knowledge, skill, judgement or care;
- A contravention of the Act or Regulations;
- Failure to comply with a condition on registration, or an order or direction of the Board or a

disciplinary body;
- Any other improper or unethical conduct relating to the practice of the profession.

A number of additional matters have been identified as appropriate for inclusion in the definition:
- Failure to respond to a Board request for information without reasonable excuse;
- Over-servicing;
- Failure to disclose a conflict of interest.

Recommendation 26 – Definition of Misconduct

It is recommended that Act define 'unsatisfactory professional conduct' as:

- Any conduct which demonstrates a lack of adequate knowledge, skill, judgement of care;
- A contravention by the practitioner of the Act or Regulations;
- A failure by a practitioner to comply with conditions on registration, or with an order or determination of the Board (or other relevant disciplinary body);
- Conduct which involves:
  (a) providing a service of a kind that is excessive, unnecessary or not reasonably required for that person's well-being; or
  (b) influencing or attempting to influence the conduct of a practitioner in a manner which would constitute professional misconduct or unsatisfactory professional conduct;
- Failure to disclose information of a type prescribed by the Regulation (eg pecuniary interests);
- Failure to respond to a Board request for information without reasonable excuse; and
- Any other improper or unethical conduct relating to the practice of the profession that would render the person unfit in the public interest to practise optometry.

It is recommended that the Act define “professional misconduct” as unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising optometry or the removal of the practitioner’s name from the register.

Codes of conduct

More recent health professional registration Acts make provision for Boards to develop or make codes of professional conduct. The Department considers there is a need to establish codes of professional conduct within legislation regulating the optometry profession.

The potential anti-competitive effect of codes can only be considered once the content of the code is known. It is therefore essential that the processes for developing the code ensures that appropriate consultation occurs and that regard is had to the costs and benefits of specific restrictions, and alternatives. The Department therefore supports making the code by Regulation.

Recommendation 27 – Codes of Conduct

It is recommended that the:

(a) Minister may approve a code of professional conduct developed by the Board.
(b) The Board must release a draft code and impact assessment report for public comment.
(c) The legislation clarify that a breach of the code may be considered as evidence of unsatisfactory professional conduct or professional misconduct.

Dealing with complaints

The Department has identified the two models for the handling of complaints through disciplinary action for the purposes of further consultation with stakeholders.

Option 1 would involve the establishment of the two-tiered disciplinary system as used under the Medical Practice Act 1992, and the Nurses Act 1991. Professional Standards Committees (PSCs) would deal with less serious complaints of unsatisfactory professional conduct and a Tribunal would deal with serious complaints of professional misconduct. The relevant Board no longer has a role in determining whether a practitioner has been guilty of inappropriate conduct.

Option 2 is based on the complaints handling and disciplinary model which exists under the *Dentists Act 1989*. The disciplinary structure in the Dentists Act provides, amongst other things, for the Dental Care Assessment Committee (DCAC) to conciliate and investigate complaints about dentists and make recommendations to the Board for their resolution. A Tribunal would be established to deal with serious matters involving professional misconduct while the Board would conduct hearings into unsatisfactory professional conduct.

It is recognised that the second model has not been the subject of prior consultation.

The Department recommends the second option primarily because it establishes a more consumer focussed and responsive complaints handling system. In particular, it allows for a broader range of complaint matters to be dealt with. Further, the experience of the Dental Board is that the DCAC performs a useful function for consumers, responds to claims in a prompt manner, and is a less costly alternative for consumers than pursuing legal action through the courts or tribunals. It represents an effective way of dealing with consumer complaints, the vast majority of which relate to the less serious end of the misconduct scale or to disputes as to whether consumers have received treatment of value.

Recommendation 28 – Dealing with Complaints

That further consultation be undertaken during drafting of legislation to regulate the optometry profession on a revised disciplinary structure whereby:

- An Assessment Committee will be established to consider and investigate complaints, referred from the relevant Board, regarding professional fees and standards of professional services.
- The Assessment Committee will be able to conciliate and investigate consumer complaints and to make recommendations to the relevant Board for the resolution of those complaints or any further action the Committee considers should be taken.
- When a Committee recommends that there be an inquiry into unsatisfactory professional conduct or professional misconduct the Board must conduct an inquiry or refer the matter to the Tribunal for a hearing.
- The relevant Board will hear complaints of unsatisfactory professional conduct following investigation of a complaint by an Assessment Committee, the Health Care Complaints Commission or the Board's own inspector.
- A Tribunal will be required to hear complaints of professional misconduct.
- Procedures are put in place for the handling of complaints based on the provisions of more recent health professional registration legislation.

Recommendation 29 – Powers for the Conduct of Proceedings

It is recommended that the Act regulating the optometry profession include powers for the conduct of proceedings by the Board/Tribunal based on the provisions of Part 11, Part 12 and Schedule 2 of the Medical Practice Act 1992.

Recommendation 30 –Continuance of Disciplinary Action

It is recommended that the Act clarify that disciplinary action may continue against a person who ceases to be registered.

11. Administration of the Optometrists Act and Other Issues

The Department supports increasing the size of the current Board from seven to nine. While this would undoubtedly result in higher costs through payment of fees to Board members, it would also allow a broader range of experience to be represented on the Board, including consumer and public representatives. Further, it would allow the workload of the board to be spread more evenly among members.

The Department supports the principle that the Board should have a sufficient mix of nominees to enable it to carry out its functions. As is the case with other health professional registration boards, it is necessary to have a majority of optometric members on the Board to enable it to carry out these functions. Although it is not suggested that the current Board members have sought to operate in a protectionist manner, it is critical that there is an appropriate mix of non-optometric board members to ensure the Board is seen to operate in an open and transparent manner. This is provided for by recommendations made below.

The nomination of optometric members is an important consideration. While it is clear that the OAA represents an overwhelming majority of optometrists, it is questionable whether one particular professional association should have a dominant role in the appointment of Board members. (Currently responsibility is shared between two professional associations). New associations may emerge which could seek such a role in nomination of board members. To overcome this problem, the Department supports an approach whereby relevant professional associations provide names generally, from which the Minister selects the nominees.

It is the Department's view that appointment of a medical practitioner to the Board is no longer considered appropriate. While concerns about the expanded therapeutic role of optometrists are noted, decisions regarding the scope of that role and the training required will be made by the Minister who can seek medical advice directly from the Department or medical associations or colleges.

There is strong support for community representatives on the Board among submissions. Accordingly the Department supports appointment of two community representatives to the board.

Recommendation 31 – Composition of the Board

It is recommended that the Optometrists Registration Board be reconstituted as follows:

- Four registered optometrists selected by the Minister from nominations provided by

optometric professional associations or by other interested parties;
- One registered optometrist selected by the Minister from nominations provided by universities providing optometric education in NSW;
- One barrister or solicitor nominated by the Minister;
- One officer of the NSW Department of Health or area health services nominated by the Minister; and
- Two people (not being registered optometrists) to provide a consumer and community perspective.

Recommendation 32 – President and Deputy President

It is recommended that the Act provide for appointment of a President (who must be a registered optometrist) and Deputy President as provided for in other health professional registration Acts.

Tenure of Board members

The Issues Paper considered the issue of whether the terms of Board members should be limited to ensure that new people are able to obtain appointment to the Board. While such people would be able to contribute alternative ideas, this concern needs to be balanced with the need to obtain experience on the Board.

Recommendation 33 – Tenure of Board Members

It is recommended that the Act limit Board members to serving only three consecutive three-year terms.

Recommendation 34 – Sub-committees

It is recommended that the Board be empowered to establish sub-committees consisting of both Board members and non-Board members and that members of such committees be entitled to remuneration.

Education and Research Account (ERA)

It is the Department's view that there are over-riding public interest benefits to support the establishment of such an account. The intent of such provisions is not to encourage research into products that will deliver 'private' benefits for individual optometrists or optical suppliers. It is the Department's intention that funds in an ERA would be directed towards conducting research into issues such as standards among professionals, rates of adverse events, drug use among practitioners and other professional issues which relate to the provision of safe and effective services to the public. Alternatively, funds could be directed towards educating consumers about the provisions of the Act including their right to make complaints. Submissions highlighted the lack of information available to consumers to assist them to make informed decisions when seeking services.

Recommendation 35 – Education and Research Account

It is recommended that Act provide for the establishment of an education and research account.

1. INTRODUCTION

1.1 Background to the Review

The current NSW Optometrists Act was enacted in 1930. The Act creates the Board of Optometrical Registration and provides that only those people who possess appropriate tertiary qualifications and who are of good character may register with the Board and engage in the "practice of optometry" as defined in the Act. The Act has been under review for a number of years and an exposure draft Bill was released in 1993.

In more recent years new legislation has been introduced in NSW to regulate the chiropractic, medical, nursing, osteopathy, podiatry and psychology professions. Significant changes have been made to the definitions of professional misconduct, to disciplinary structures, to registration criteria and to the level of consumer representation on boards in these Acts.

In April 1995 the Council of Australian Governments (COAG) agreed to the Competition Principles Agreement. The Agreement commits Commonwealth, State and Territory governments to consider, review and, where appropriate, reform the potentially anti-competitive effect of all legislation. The NSW Government is committed to the review of all legislation in accordance with this agreement.

In June 1996, the Minister for Health established a working party to consider a range of clinical issues that have arisen during the review of the Optometrists Act. The Clinical Issues Working Party was asked to provide advice on access to therapeutic drugs, contact lenses, the use of lasers and the scope of the practice of optometry.

1.2 The Current Review

To facilitate the review process, the Department prepared an Issues Paper which was released for public comment in July 1998. The Terms of Reference for the current review are detailed in **Appendix A.**

Comments were sought from consumers, government bodies, optometrists, professional bodies, other health care professionals and all interested parties on the Competition Principles Agreement issues and other possible changes to the Act.

Twenty-five submissions have been received from interested parties - see **Appendix B**. To further facilitate the review process the submissions received were circulated among those individuals and organisations that made submissions to the review. Seven supplementary submissions were received from those that had already made submissions. A further two submissions from organisations that had not previously made a submission to the review were received.

Immediately prior to the release of the Issues Paper, the Department engaged ACIL Consulting to undertake an economic appraisal of the options for regulation of the optometric industry pertaining to registration, practice and ownership. The purpose of this consultancy was to obtain an additional independent assessment of regulatory options accompanied by detailed economic analysis. ACIL consulted with organisations during June 1998 and provided the Department with a Report in July of that year, *Regulatory Options for the NSW Optometric Industry – Economic Evaluation*. The Executive Summary for this report is provided at **Appendix C**

1.3 The Final Report

The Department has prepared this Report for consideration by the Minister for Health and the NSW Government in satisfaction of the review requirements under the Agreement. While this report is directed primarily at addressing the issues arising by way of the Competition Principles Agreement, other matters considered during the review are identified and addressed where appropriate.

2. THE REGULATION OF OPTOMETRISTS AND OTHER SERVICE PROVIDERS

2.1 Introduction - The Provision of Eye Care Services

Optometrists provide a range of eye examination and vision correction services to the public. These services include the examination of the eyes and measurement of their functions and powers; remedying and relieving an abnormality or defect of sight by way of an optical appliance or orthoptic treatment; and the prescribing, dispensing and fitting of spectacles and contact lenses.

Optometrists must complete a four-year Bachelor of Optometry at the University of New South Wales, or equivalent interstate qualification. Virtually all optometrists operate from private rooms. As at 30 June 1998 there were 1260 registered optometrists in NSW.

Optometrists play an important role in the wider market for eye care services. Based on information provided in the Health Insurance Commission's annual report for 1996/7, Medicare rebates in excess of $130 million were paid in NSW for consultations by optometrists and ophthalmologists. In addition private health funds paid benefits in excess of $55 million for optometrical and ophthalmological services as well as the dispensing of glasses by optical dispensers and treatment by orthoptists. In total the eye care market in NSW was worth in excess of $185 million in 1996/7, of which optometrists are estimated to have contributed $80 million.

There are a number of professionals other than optometrists who provide eye care services.

Ophthalmologists are specialist medical practitioners who provide specialist medical eye care services including surgery. Many ophthalmologists also provide "consulting" services in competition with optometrists including the issuing of prescriptions. Ophthalmologists practise in both public and private hospitals, as well as consulting from private rooms. The Australian Medical Workforce Advisory Committee estimates that there were approximately 260 ophthalmologists in practice in NSW in 1994/5.

General practitioners provide primary eye care treatment and refer patients to ophthalmologists or optometrists for more specialised treatment. Although able to, few issue prescriptions for contact lenses or glasses. General practitioners practise almost exclusively from private rooms.

Orthoptists also provide a limited range of eye care services. The Optometrists Act 1930 defines "orthoptic treatment" as *the employment of ocular exercises for the correction, remedying or relief of any abnormality or defect of sight.* Orthoptic treatment within the meaning of the Act may only be carried out on the direction or reference of a legally qualified medical practitioner or registered optometrist. The Orthoptic Association of Australia argues that orthoptists specialise in the investigation, diagnosis and non-surgical management of disorders of the eye. Orthoptists practise in the hospital system as assistants to ophthalmologists, and a small number practise from private rooms where they receive referrals primarily from ophthalmologists. Orthoptists are self-regulated with virtually all practitioners belonging to the Orthoptic Association of Australia (OAA). There are at present 148 members of the NSW branch of the OAA.

Optical dispensers perform the function of dispensing optical appliances to the prescription of an optometrist or ophthalmologist. They are not permitted to prescribe such appliances. Optical dispensers overwhelmingly practise as employees of the large dispensing firms or in private practice. As at 30 June 1997 there were 1315 optical dispensers licensed in NSW by the Optical Dispensers Licensing Board.

Orthoptic nurses undertake some eye care activities and a range of people in the community, including aboriginal health workers undertake visual screening.

2.2 The Optometrists Act 1930

The long title of the Optometrists Act 1930 is as follows:

> *An Act to provide for the registration and to regulate the practice of optometrists and for purposes connected therewith.*

There is no clear statement of objectives contained in the legislation at present. The possible objectives of legislative intervention are discussed in Chapter 3.

The Board

The Act creates the Board of Optometrical Registration, a body corporate, which may exercise and discharge the powers, authorities, duties and functions conferred by the Act (section 5). The Board consists of seven members:

- (i) Two registered optometrists nominated by the Australian Optometrical Association (NSW);
- (ii) one registered optometrist nominated by the Opticians and Optometrists Association of NSW;
- (iii) one legal practitioner nominated by the Minister;
- (iv) one legally qualified medical practitioner nominated by the Australian Medical Association;
- (v) one registered optometrist nominated by the University of NSW;
- (vi) one officer of the NSW Department of Health.

One of the registered optometrists on the Board is to be the chairperson of the Board. Members are appointed for terms of three years and may be reappointed.

Register

The Act provides for the establishment of a register of optometrists in the manner and form set our by the Act and Regulations. (Section 11) The Board has the power to issue and cancel certificates of registration. A person may only be granted registration where he or she:

- (i) proves to the satisfaction of the Board that he or she is of good character and has attained the age of 21 years; and
- (ii) holds one of the qualifications set out in the Act or recognised by the Board (Section 19).

If a person holds qualifications in optometry, but they are not qualifications recognised by the Act or Board, the person may complete limited additional training and/or sit an examination conducted by the Board (Section 19).

Restrictions on title and practice

Persons registered under the Act are entitled to practise optometry (Section 24(1)). Section 24(2) of the Act prohibits unregistered persons from practising optometry which is defined as follows:

> "*Optometry" or the "practice of optometry" means the doing or performing of any one or more of the following acts, matters or things, that is to say, the examination of the eyes and the measurement of their functions and powers, with the object of determining whether there is any, and if so, the nature or degree of any abnormality or defect of sight, the correction, remedying and relieving of any abnormality or defect of sight by means of an optical appliance or orthoptic treatment, and optical dispensing, but does not include visual screening.*

The prohibition contained in section 24(2) does not prevent any person from:

(i) carrying out optical dispensing if the person is authorised under the Optical Dispensers Act 1963;
(ii) engaging in the craft of lens grinding or spectacle making;
(iii) a person from carrying out orthoptic treatment under or upon the direction, prescription or reference of a medical practitioner or optometrist;
(iv) a student from practising under supervision.

Unregistered persons are also prohibited from taking or using the titles "optometrist", "optician" or other name, title or designation implying that he or she is registered under the Act or is qualified to practice optometry. Registered optometrists may not use any other titles unless the Board has approved the title.

Restrictions on medical practice

Section 20 of the Act prohibits persons other than legally qualified medical practitioners from:

(i) practising or holding out as entitled to practise the profession or calling of an oculist or ophthalmic surgeon;
(ii) assuming the title oculist[1] or ophthalmic surgeon or any other name implying that the person is a medical practitioner or is qualified to practise ophthalmology or ophthalmic medicine or surgery;
(iii) prescribing or administering drugs to paralyse the accommodation of the eye;
(iv) sell or supply any drug or remedy for treating any disease of the eye.

---

1 The Macquarie Dictionary defines an oculist as *"a doctor of medicine skilled in the examination and treatment of the eye; an ophthalmologist"*.

Registered pharmacists are exempt from the prohibition contained in (iv).

Notwithstanding section 20, registered optometrists are permitted to prescribe drugs in the practice of optometry (including those that will paralyse the accommodation of the eye) where they hold a certificate issued by the Board of Optometrical Registration (Section 29A). Only those drugs that are prescribed by the Act or Regulation may be used by optometrists. In view of the limited definition of the practice of optometry, registered optometrists may only administer drugs for diagnostic purposes and not for treatment.

Restrictions on the ownership of optometric practices

Firms, companies and unregistered persons are prohibited by section 35 of the Act from carrying on "the business of the practice of optometry". As a consequence, optometric practices may only be owned and operated by registered optometrists. A limited number of companies have been grand-fathered under the Act so that they may continue to operate practices in limited circumstances.

Complaints and Disciplinary Systems

Section 15 of the current Act provides that the Board may reprimand, caution or remove from the register a practitioner who has been convicted of an offence which would be a felony or misdemeanour if committed in NSW, or if the practitioner has been subject to an inquiry by the Board and judged to be guilty of misconduct in a professional respect. The statutory definition of misconduct in a professional respect in the Optometrists Act 1930 identifies three specific types of misconduct including:

(i) practising optometry in a name other than the registrant's own, except when a duly appointed locum tenens[2]:
(ii) advertising or soliciting for business in contravention of the Regulations;
(iii) being a habitual drunkard or addicted to any deleterious drug.

Other matters, such as lack of competence, are determined under the common law. Historically the common law recognised "professional misconduct" or "misconduct in a professional respect" as conduct of a nature which would attract the "gross reprobation of one's peers of good standing and repute", as defined in the case of *Qidwai v Brown*. The Act provides for the Board to hold an inquiry and to sit in open court with the practitioner in question able to be represented by counsel.

In accordance with the provisions of the Health Care Complaints Act 1993 (HCC Act), a complaint may also be made to the Health Care Complaints Commission. Processes are put in place to ensure that complaints are handled in a coordinated manner.

Complaints made to the Board are deemed to be a complaint made to the Commission and are referred. Action on a complaint is then determined through consultation between the Board and the HCCC. Matters can be referred for conciliation by the Health Conciliation Registry, referred for

---

2 Although this phrase is not defined by the Act, the Macquarie Dictionary defines locum tenens to mean "one holding the office of another". A locum tenens would conduct the practice of the optometrist in their absence, but only on a temporary basis.

investigation to the HCCC or dismissed. Where there is disagreement between the HCCC and Board as to what action should be taken on a complaint, the view of the body that takes the most serious view of the matter will prevail. Following an investigation, the HCCC may refer the matter back to the Board with a recommendation that an inquiry under section 15 be conducted.

2.3 Other Legislation

The provision of optometrical services is also regulated through general consumer protection laws such as the Commonwealth ***Trade Practices Act 1974,*** administered by the Australian Competition and Consumer Commission, and the NSW ***Fair Trading Act 1987*** administered by the NSW Department of Fair Trading. These prohibit optometrists from making false and misleading representations in the course of providing a service, for example, falsely claiming to hold qualifications or membership of professional associations.

In the case of a dispute between a health professional and a consumer, either party could seek to resolve their differences through the civil court system, although it is recognised that this is generally an expensive process and is unsuitable for minor complaints. As an alternative such matters can also be heard before a Consumer Claims Tribunal which has the objective of providing a simple low cost mechanism for dispute resolution. Complaints about fees may also be pursued before that Tribunal.

2.4 The Role of Professional Associations

In addition to the registration board, professional associations play a role in monitoring standards among optometrists. The largest professional association is NSW is the Optometrists Association of Australia (NSW Branch). The OAA sets standards for membership and requires members to observe a Code of Ethics as a condition of membership.

There are a number of smaller professional associations, colleges and similar organisations with varying roles in representing the profession and monitoring professional standards.

2.5 Other Service Providers

There are a number of health professionals or para-professionals that provide some (or all) of the services that are ordinarily provided by optometrists as noted above. These practitioners are limited in their practice by the provisions of the *Optometrists Act 1930* as set out in section 2.1 of this Report.

Medical practitioners, optical dispensers and nurses have statutory registration boards similar to that established for the optometry profession. Orthoptists have a self-regulatory system whereby a Board, established under the auspices of the Royal Australian College of Ophthalmologists, registers orthoptists on a voluntary basis.[3]

2.6 The Regulation of Optometry in Other Jurisdictions

3 The Orthoptic Association of Australia has advised that the registration Board is currently being re-established independently of RACO.

Optometrists are registered in all Australian jurisdictions and New Zealand. A summary of the main features of legislation regulating optometry in other jurisdictions is provided at **Appendix D**.

New optometric legislation was enacted in Victoria in 1995 and in Tasmania in 1996. In Victoria, significant reforms were implemented to:

- grant optometrists access to therapeutic drugs;
- to remove the restrictions on the conduct of optometric practices by persons other than optometrists and corporations; and
- to enable orthoptists to be able to prescribe glasses.

The Victorian Government, however, elected to retain a broad restriction on the full scope of optometric practice including diagnosis of abnormalities of the eye, and the prescribing of glasses and contact lenses.

Tasmania has introduced legislation to allow optometrists to prescribe therapeutic substances in the course of optometric practice. That State retains a broad restriction on the practice of optometry without exemptions.

The Queensland Government is conducting reviews of all health professional registration legislation including the Optometrists Act 1930. Queensland Health in its Draft Policy Paper, *Review of Medical and Health Practitioner Registration Acts,* has identified a significant reform proposal. The paper notes that health professional registration Acts have traditionally sought to define the whole "scope of practice" of the profession. Unregistered practitioners are then prohibited from engaging in any practice that falls within the scope of the defined "scope of practice". This has a number of problems that are discussed in more detail latter in this Report (See Chapter 4). Queensland Health has identified as its preferred position the following:

> *Given the difficulties of the conventional approach to the regulation of practice, the preferred position is that a new statutory method, involving regulation of "core restricted practices" be used to protect the public.*
>
> *Rather than a statutory definition to restrict a broad scope of practice, it is proposed that certain "core restricted practices" be restricted to specified professions only.*

Decisions on what are to be the "core restricted practices" would be made after considering technical advice having regarding risks to public health and safety. In relation to optometry, the core practices are identified as prescribing optical appliances for the correction of relief of visual defects and the fitting of contact lenses.

The Department of Health understands that consultation is continuing in relation to this issue. Further Queensland Health is separately reviewing the current restrictions on the ownership of optometrical practices that exist in that State.

Other States are also progressing reviews of professional registration legislation under the Competition Principles Agreement.

2.7 Impact of the Legislation on Competition

Legislative controls imposed by Government often have positive outcomes for the community where they effectively address problems that arise from the provision of services in an unregulated environment. These are sometimes known as 'market failures'. An example of such a problem is where there is an imbalance of information between service providers and consumers, limiting the ability of the latter to make informed choices when seeking service providers. However, regulation may also restrict competition among service providers. This may result in new problems or costs for business, consumers and government that are not justified having regard to the nature of the problem which the intervention was seeking to address. Alternatively, regulation may not be effective in addressing the identified problems.

The principal (but not all) requirements of the Act, which were identified in the Issues Paper as potentially having an impact on competition, can be summarised as follows.

(i) People who are not registered as optometrists, or exempted under the Act, cannot practise optometry as defined by the Act or use the term 'optometrist'.

(ii) People who are not registered as optometrists, firms and corporations cannot own or operate an optometry practice.

(iii) Optometrists are not permitted to use therapeutic drugs in the practice or optometry or assume titles implying medical qualifications.

(iv) Orthoptists are restricted to providing orthoptic treatment under the direction of a registered medical practitioner or optometrist.

(v) Optical dispensers are restricted in the services that they may provide.

(vi) Disciplinary and complaints systems, particularly where they inappropriately restrict legitimate commercial conduct without delivering benefits to the community as a whole.

The principle of the Competition Principles Agreement guiding the current review is that the costs arising from the restrictions outlined above should be outweighed by the benefits they produce, and the objective of the legislation, as canvassed in Chapter 3, can only be met by restricting competition.

This paper assesses the current requirements to determine whether they accord with the principle outlined above. In addition, a range of new regulatory requirements were canvassed in the Issues Paper and these are also assessed to ensure that they accord with the review principle.

The NSW Government recognises that serious, and often irreversible, adverse consequences may flow from the provision of eye care service by incompetent or negligent service providers. In considering whether restrictions on competition should be retained or modified, it should be noted that the Government will not support changes where there is clear evidence demonstrating that such changes will expose the public to an unacceptable risk of injury or harm.

2.8 Other Market Restrictions: Access to Medicare Rebates

Optometrists, like medical practitioners, have access to rebates under the Commonwealth *Health Insurance Act 1973*. This legislation establishes the Medicare system and access to rebates for certain optometric services has been provided for under Medicare since 1984.

To participate in Medicare optometrists must enter into a Common Form of Undertaking with the Government by which optometrists agree to comply with certain conditions. The most significant of these conditions are the following:

(i) optometrists may charge no more than the Medicare Benefits Schedule (MBS) fee for service;
(ii) benefits for contact lens consultations are payable only if certain conditions are met;
(iii) patients are referred to medical practitioners where clinically necessary; and
(iv) a patient can only claim an initial consultation with an optometrist once every two years.[4]

The Undertaking precludes optometrists from charging more than the MBS fee. As a consequence there is little or no competition in respect of consultation fees between optometrists. Notwithstanding the lack of competition, over the seven-year period from 1984-5 to 1991-2 the average fee for optometrists fell in real terms by 24%. Further, with over 90% of services undertaken by optometrists being bulk-billed, there are few if any ‘gap payments’ required to be made by consumers. Practitioners do not charge above the schedule fee because their patients would not be able to obtain a rebate from Medicare.

No similar restrictions apply to ophthalmologists other than for some contact lens services. For services provided by ophthalmologists, the practitioner determines fees and there is no upper limit set by Medicare at which time benefits will cease.

It should be stressed however, that not all optometric services attract a Medicare rebate, for example, fees relating to the fitting of contact lenses. In these areas there are out of pocket expenses incurred by consumers and competition between practitioners in relation to fees. Similarly, there are no Medicare rebates available in respect of glasses.

---

4 Access Economics *Vision Care in Australia: Focussing on the Role of Optometry* (Report prepared for the Australian Optometrical Association) Canberra June 1993.

3. THE OBJECTIVES OF LEGISLATION REGULATING OPTOMETRY

3.1 Introduction

To comply with the COAG Competition Principles Agreement, the NSW Government is required to identify the objectives of the *Optometrists Act 1930* and to consider whether there is a rationale for achieving these objectives through legislation. If it is established that there is a rationale for legislative intervention, the precise form of intervention, that is registration by title or alternative means, needs to be considered. This is done in the next chapter.

As noted above at 2.2, there is no clear statement of objectives in the current Act, although the then Minister stated when introducing the Bill in 1930 that:

> "*It is the object of this Bill to ensure that persons who are in the habit of treating people who suffer from defects of the eye shall be capable of prescribing the proper lenses...*"
>
> "*The consequence of unqualified people undertaking to prescribe lenses is that not only are glasses given to individuals which often do their eyes more harm than good, but frequently most excessive charges are made for glasses which are practically, if not entirely, plain glass. It has become notorious how much extortion is practised on people who are ignorant as regards the qualifications of persons to who (sic) they go to get their eyes tested, and as I said, in many cases injury is often done to the eyes owing to the wrong glasses being prescribed...*" [5]

Based on this the Department identified in the Issues Paper a number of possible objectives of the legislation for discussion including:

- Protection of consumers from incompetent or fraudulent service providers. The specific harm targeted by the Act would presumably be eye damage through incorrect diagnosis and/or prescription of glasses and financial costs imposed on consumers.

- Minimisation of the risks of harm of delayed diagnosis and treatment. Amendments to the Act in 1963 to provide optometrists access to diagnostic drugs recognised optometrists also play a role in screening (but not treating) eye disease.

The Department sought comments in the Issues Paper from interested parties on the following issues:

(i) Whether the objectives of the Act had been appropriately identified, and whether the objectives of the Optometrists Act 1930 are still valid;

(ii) What problems might exist with the provision of optometric services in an unregulated environment and are they being adequately addressed by the Act.

5 Legislative Assembly Hansard, 6 May 1930 at page 4850

3.2 Submissions

Of the seven submissions that considered the objectives of the legislation, six agreed that the principal objective should be the protection of consumers from the risk of harm from incompetent or fraudulent service providers. Only the Optometrists Association of Australia (NSW Branch) (hereinafter the OAA (NSW)) proposed that the objectives of the legislation should in fact be broader:

> *In summary the objectives of the Optometrists Act in 1998 should be:*
>
> - *Protection of consumers from incompetent or fraudulent providers;*
> - *Ensuring appropriate professional standards from optometrists;*
> - *Minimisation of harm from delayed or missed diagnosis or treatment;*
> - *Facilitating optometrists to carry out their role as the first-choice providers of primary eye care to the people of NSW."*[6]

Clearly, the appropriateness of objectives of the legislative intervention can only be determined by reference to the problems that exist in the unregulated environment. Most submissions highlighted the potential risks of harm to consumers in an unregulated environment, although limited quantitative evidence has been provided to demonstrate this point (presumably because it is not available). The OAA (NSW) states in its submission that:

> *"…an unregulated environment for optometric practice would carry with it very substantial risks to the health of the people of NSW"*[7]

While an advantage of an unregulated environment cited by the OAA (NSW) would be more service providers in the marketplace, the OAA cites a list of disadvantages including the following:

> *"**Disadvantages:***
>
> - *Missed diagnosis of both ocular and systemic disease;*
> - *Inappropriate treatment of visual dysfunction (treating a pathology as if it were a refractive error);*
> - *Unnecessary prescriptions for optical appliances;*
> - *Inaccurate prescriptions;*
> - *Commercial pressures over-riding professional obligations;*
> - *Increased expense for consumers as Medicare benefits would most likely be withdrawn if optometric services were to be deregulated;*
> - *Confusion of the public due to the disparity in skills and knowledge between optometrists and other service providers;*
> - *Reduced standard of care;*
> - *Lack of community support for non-optometrists due to the absence of Medicare benefits for services;*
> - *A likelihood of inappropriate prescriptions and referrals due to others' inadequate*

6 Submission from the Optometrists Association Australia (NSW), 10 August 1998, at page 8
7 Ibid at page 1

knowledge base;
- *Increased costs to the community, as others will need to charge more than optometrists for an inferior level of service."* [8]

The Board of Optometrical Registration raised similar concerns:

"Deregulation of the provision of optometrical services would likely lead to an increasing demand for medical services...

Another potential problem in an unregulated environment is that consumers could be provided "optometrical" services by unqualified or insufficiently qualified practitioners. This development could potentially result in serious eye conditions going undetected."[9]

The Australasian Dispensing Opticians Association stated:

"These problems would include the risk of physical harm and the associated social costs resulting from such harm, and would arise as a result of a lack of understanding in the community of the various ophthalmic professions in an unregulated environment."[10]

The Health Care Complaints Commission suggests the following:

"The experience of the Health Care Complaints Commission is that consumers of health services expect a high standard of accountability by persons providing health services. A system whereby optometrists were unregulated or subject to only self regulation would not meet consumers expectations of high professional standards and accountability in the profession of optometry." [11]

Other stakeholders focussed more directly on the underlying problems of a deregulated market. The Optical Dispensers Licensing Board suggested the following:

"The Optical Dispensers Licensing Board wishes to highlight that although the public has a high degree of awareness of the role of the optometric profession and those conditions and treatments for which they should consult an optometrist, it is unlikely that they will be informed as to the qualifications and skills which are required to make a practitioner safe or competent...

The Board considers that a system which is based on a competitive market to ensure a flow of information to consumers is flawed in that it fails to take into account differences between consumers ability to gather and analyse information and their willingness to seek out the information in the first place. Further taking a "buyer beware approach" does not adequately consider the social costs caused by eye disease and improper diagnosis."[12]

---

8 Ibid at page 1 and 2
9 Submission from the Board of Optometrical Registration dated August 1998 at page 3
10 Submission from the Australasian Dispensing Opticians Association, 11 August 1998 at page 1
11 Submission by the Health Care Complaints Commission, 14 August 1998, at page 1.
12 Submission by the NSW Optical Dispensers Licensing Board, 13 August 1998.

3.3 Objectives of the Act - Protection of Consumers from Harm

Protection of consumers from harm is consistently identified in submissions as the principle objective of the legislation. The Department supports this view. While there is little clear quantitative evidence that establishes an underlying rationale for this objective there is substantial qualitative evidence to establish a rationale for legislative intervention.

The submission from MBF succinctly sets out the problem or market failure of an unregulated market:

> *"The lack of information in the provision of the eye care appliances is rather evident in this industry...MBF feels it is not sufficient to just identify the existence of the "imperfect information" problem – this problem needs to be eliminated. At present two areas in which the lack of information to the consumers of eye care services are:*
>
> - *Lack of knowledge about suitability of different types of eye care professionals and their educational/qualifications;*
> - *Lack of information about the appropriateness as well as quality of services and aids/appliances provided by these professionals."* [13]

Lack of information about appropriateness of appliances

While a number of complaints primarily relate to advertising, it can be seen that over recent years there have been a substantial number of complaints relating to treatment. In the most recent reporting period, five complaints related to treatment. The outline of these complaints provided in the annual Report tends to provide some evidence for the imbalance of information that exists between consumers of optometrical services and the practitioner:

> *"In one case the complainant alleged that spectacles prescribed by the optometrist to the complainant's son had caused a headache, and subsequent eye examinations by another optometrist and an ophthalmologist had indicated that no spectacles were required..."*[14]

And in another case, the Board reported the following:

> *"In one case the complainants, a husband and wife, alleged that the optometrist concerned had dispensed "multi-focal" spectacles which were not comfortable, and "bi-focal" spectacles which resulted in blurry vision"* [15]

These cases highlight an imbalance of information between practitioner and consumer. Patients cannot assess the quality of glasses, or whether they need glasses at all. While it is clear that these cases do not provide evidence of serious physical harm, they do establish that there is an imbalance of information that may result in unnecessary financial cost to consumers through the inappropriate

---

13 Submission by MBF Ltd, 17 August 1998. It should be noted that MBF also suggests that the current Act of itself does not adequately address the problems of market information. This issue is discussed in more detail latter.

14 NSW Board of Optometrical Registration *Annual Report for the Year Ended 30 June 1998* at page 9.

15 Ibid at page 9

prescription of optical appliances. In should also be noted that the Department of Fair Trading and the Health Care Complaints Commission receive complaints about optometrists, which are summarised in **Appendix E**.

Lack of information regarding quality of services

Research suggests that patient satisfaction is related to the perceived interpersonal and communication skills of practitioners rather than technical quality.[16] The eye care market is no different where consumer satisfaction does not appear to be related to technical quality even for those specially trained, or more informed, consumers of eye care services.[17]

The inability of consumers to assess the technical quality of service provided has the potential for significant harm. As noted by many submissions, patients have a relationship of trust with the practitioner and they rely on the practitioner to effectively diagnose their condition, and provide appropriate treatment. While there is little Australian evidence to support claims of serious physical harm arising from the lack of information regarding quality of services, there is considerable material available from the United States relating to malpractice litigation.

For example, a review of 50 malpractice claims in the United States between 1977 and 1989 highlights the potential risks associated with optometric practice including:

- Misdiagnosis of ocular disease including retinal detachment, open angle glaucoma, ocular tumours, brain tumours, ocular foreign bodies, diabetic retinopathy, and histoplasmosis (31 cases);
- Failure to provide appropriate treatment in relation to contact lenses (8 claims);
- Failure to prescribe appropriate therapeutic agent (4 claims);
- Adverse effects of diagnostic agents (2 cases)
- Failure to prescribe appropriate spectacles (3 cases); and
- Failure to treat binocular vision/amblyopia. [18]

While this material does not provide any indication of the level of risk involved in optometric profession, particularly in comparison to other professional groups, it does highlight the serious adverse consequences that can arise in an unregulated market. Further it is important to note that if an expanded therapeutic role were introduced, as recommended below, the potential for harm would be further increased and appropriate regulatory measures would be needed to protect patients from harm.

Lack of knowledge about suitability of different types of eye care professionals and their educational/qualifications

The role of various eye care professionals was summarised earlier in this Report. While there is no

---

16 Cleary PD, McNeill BJ "Patient satisfaction as an indicator of quality of Care" (1988) *Inquiry* 25 at p 25. Haas Wilson, D "The Relationships Between the Dimensions of Health Care Quality and Price: The Case of Eye Care" (1994) 32 *Medical Care* 2, pp 175-182 at p 176.

17 Haas Wilson, D (1994), op cit at p 182

18 Classe, J G, "A review of 50 malpractice claims", *Journal of the American Optometric Association* Vol 60 Number 9, 1989 at page 694.

quantitative evidence is available to demonstrate that consumers lack understanding of the roles and respective qualifications required for each professional group, it is reasonable to postulate that there is likely to be some degree of confusion among patients when seeking services after considering the comments made by various submissions outlined above.

3.4 Objectives of the Act – Facilitating optometrists' role as providers of primary eye care

The OAA (NSW Branch) has suggested that an objective of the legislation should be "facilitating optometrists to carry out their role as the first-choice providers of primary eye care to the people of NSW."[19] The OAA submission fails to clearly articulate a rationale for recognition of this as an objective of the legislation, although the submission does suggest that if registration were removed then it is likely that Medicare benefits would be withdrawn. Presumably, this would undermine access to services of optometrists.

The Royal Australian College of Ophthalmologists (RACO) queried the pre-eminence of the optometrists' role in relation to primary eye care:

> *"To the best of our knowledge, the claim that optometrists already provide 75 per cent of all primary eye care examinations in Australia is simply not correct. It is true that the great bulk of pure refraction is now carried out by optometrists who also play a useful role in screening for abnormalities. However, primary eye care in the medical sector continues to rest predominantly with GPs and Ophthalmologists".* [20]

The Department does not dispute that optometrists are an important source of primary eye care services for the community particularly in screening for eye disease and referring patients for appropriate treatment. Removal of restrictions on access to limited therapeutic substances, as recommended below, clearly facilitates this role further.

However, the Department is not satisfied that legislative intervention is necessary to recognise this role particularly as this would appear to provide optometry with a privileged position in relation to other service providers when no case has been made out that this is appropriate.

3.5 Conclusion

As noted above the OAA (NSW Branch) identified four possible objectives. Three of these - protection of consumers from incompetent or fraudulent providers, ensuring appropriate professional standards from optometrists, and minimisation of physical and financial harm from delayed or missed diagnosis or treatment – are addressed by the broad objective, protection of the public from harm. The problem, which faces those seeking to use optometric services, is the imbalance of information between practitioners, both optometric and other, and patients. The Board should be required to exercise its functions in a manner consistent with the objectives.

---

19 Submission from the Optometrists Association Australia (NSW), 10 August 1998, at page 8

20 Supplementary submission from the Royal Australian College of Ophthalmologists, 23 November 1998 at page 1

Recommendation 1 - Objective

It is recommended that the Act have the objective of minimising the risks of serious harm or injury to those seeking to use optometric services, with an express requirement for the Board to exercise its functions in a manner consistent with the objectives.

4. REGISTRATION OF OPTOMETRISTS, COMPETITION AND REGULATORY OPTIONS

4.1 Introduction

The primary form of intervention through which the Optometrists Act 1930 seeks to achieve the objectives outlined in the previous chapter is through:

- the establishment of the registration system whereby those with appropriate qualifications are entitled to be registered;
- placing restrictions on who may use the titles "optometrist" and "optician";
- placing restrictions on who may engage in "the practice of optometry" as defined by the Act.

The requirement for registration and the restriction on titles aim to achieve the objectives of the legislation by providing consumers with a simple and understandable means of identifying practitioners capable of providing the full range of optometrical services. Further, to minimise the risk of injury to consumers, unregistered people may not engage in the "practice of optometry", that is provide optometrical services. As consumers can only obtain services from registered practitioners, the risks of injury may be reduced.

Compared to other health professional registration legislation, the Optometrists Act 1930 is highly restrictive in that it restricts the use of 'title' and 'practice'.

4.2 Regulatory Options

The review principle under the Competition Principles Agreement requires the Department to consider whether the benefits of these restrictions outweighs the costs and to determine whether the least restrictive form of intervention is used to achieve the objectives of the Act. The Issues Paper identified a number of options for consideration:

<u>Option 1</u> **No regulation or self-regulation by professional associations** – Any person could engage in the practice of optometry and describe themselves as optometrists. The conduct of individuals would be subject to the Fair Trading Act 1982 and the Trade Practices Act 1974 (Cth). Complaints could be made under the Health Care Complaints Act 1993, although there would be no statutory mechanism for disciplining practitioners. Nonetheless professional associations could undertake this task within the bounds of trade practices legislation and the general law.

<u>Option 2</u> **Co-regulation** – This option is broadly similar to Option 1 except that Government would intervene, either legislatively or administratively to accredit professional associations which effectively discipline their members. Government and/or professional associations would promote the benefits of dealing with a member of an accredited association. Those that are not members of associations could, however, continue to practise and use the title optometrist

<u>Option 3</u> **Voluntary accreditation by a government or statutory body** – An accreditation

body, similar to the current Board, would accredit practitioners as competent to practise and discipline members. Optometric practitioners and unregistered persons would not be required to be accredited to practise or use the title optometrist, although they would be entitled to hold themselves out as accredited by the Board if so accredited.

Option 4 **Title regulation only** – This is essentially the same as Option 3, except that accredited/registered practitioners would be entitled to use the title "optometrist".

Option 5 **Title and core practice restrictions** – This is the same as Option 4, except that certain core practices which have been identified as carrying significant risks if carried out by unregistered persons, would be restricted to those that are registered under the Act. A variation on this option would be to grant exemptions to non-optometrists where they can demonstrate that they have sufficient competence to provide the restricted practice.

Option 6 **Title and whole of practice restrictions with exemptions -** See discussion at paragraph 4.4 below.

Option 7 **Title and Whole of Practice Restrictions** – This is the current system as outlined in Chapter 2 and summarised at 4.1. Legislation would attempt to define all of the practices that comprise the practice of optometry and restrict them to registered optometrists.

The options for regulation of the profession were considered by the Clinical Issues Working Party (CIWP) established by the Minister for Health. The CIWP noted in its Final Report that the changing roles of professional groups and developments in professional practice, make it difficult and inappropriate to define the "practice of optometry" and restrict others from undertaking any practice which falls within that definition.[21] The CIWP noted that restrictions on practice (core or whole) should only be introduced where there is a real and substantial risk of harm to consumers. The CIWP considered and endorsed the model outlined in Option 5 under which the following core practices would be restricted: the fitting of contact lenses and the prescription of optical appliances.

4.3 Submissions on Regulatory Options

Submissions provided a range of views as to the appropriate regulatory model. It is important to note that this section does not consider comments made in submissions regarding exemptions if practice restrictions are considered appropriate (see discussion below at **paragraph 4.6**).

All submissions generally rejected the appropriateness of Options 1 - 3 principally on the grounds that they provide insufficient protection to consumers from the risks of harm associated with optometric practice. This position is best summed up by a submission from MBF Ltd:

---

21 *Optometrists Act 1930 Review Clinical Issues Working Party: Report to the Minister for Health* February 1998 at paragraph 5.2 published in NSW Department of Health, Review of the Optometrists Act 1930: Issues Paper June 1998 at Appendix A.

"If this system were deregulated to the point that any service could be provided by an unqualified provider, consumers would be disadvantaged in a number of ways. Consumers are likely to:

- *think of short term benefits (cheaper services) thus be price driven, and not necessarily quality driven;*
- *not even be aware of the deregulation and the need to question the provider about their qualifications; they would just assume the provider was qualified;*
- *feel intimidated to question the authority of the potential health service provider (one of the major concern issues outlined by MBF members in the past).*

This means that consumers will be rather likely to be disadvantaged by:

- *receiving services from providers they would never have chosen would they have known their qualifications (or lack of them); or*
- *by leaving themselves open to the risk of eye damage (inappropriate treatment) due to the price driven decision making."*[22]

All submissions argue that there is a need for at least a title restriction on "optometrist".

"The public is now reasonably well informed and most people would understand the importance of visiting an optometrist for an eye check and to obtain an optical prescription. For this reason it is important to maintain the restriction on the use of the title optometrist to registered people only..."[23]

"The title has become well established in the current regulated marketplace giving comfort to consumers. Unrestricted use would effectively mislead consumers in that they could attach the current quality standards associated with the title to unqualified practitioners using the title."[24]

The majority of submissions also argued for practice restrictions, although these were divided between those arguing for core practice restrictions, whole of practice restrictions, or either type of practice restrictions but with exemptions for appropriately qualified practitioners in certain circumstances.

The Health Care Complaints Commission, the Council on the Ageing (COTA), the Board of Optometrical Registration and a few others argued that the only means of protecting the public is through title and whole of practice restrictions.

"The Commission is of the view that only title and whole of practice restriction (compulsory registration) adequately ensures protection of the public and the maintenance of professional standards."[25]

"It is as simple as this: A plumber does plumbing, an electrician performs electrical work, a

22 Submission from MBF Ltd dated 17 August 1998 at page 2
23 Submission from the Optical Dispensers Licensing Board dated 13 August 1998 at page 3
24 Submission from the Royal Australian College of Ophthalmologists dated 14 August 1998 at page 1
25 Submission from the Health Care Complaints Commission dated 14 August 1999 at page 2

dentists perform dentistry, a motor mechanic works on vehicles, the cardiologist perform heart surgery and the optometrist performs the practice of optometry."[26]

COTA stated the following:

"Furthermore, implicit in the general winding down of levels of regulation or qualifications and standards required of service providers is the potential for the health system to become divided; publicly funded services for those who cannot pay privately could become 'second-rate' – restricted to the lowest level provider, while those seeking the services of a professional optometrist would have to pay." [27]

However, the Orthoptic Association, the Australian Association of Dispensing Opticians, the Optical Dispensers Licensing Board, argued that the title/whole of practice model unjustifiably restricts competition.

"It is true that restricting the practice of optometry and the use of the title to registered optometrist is a restriction of trade. We do not consider this an excessive restriction when balanced against the public good, however permission for other occupations to carry out some of the functions of optometry under appropriate supervision ... would increase competition with no adverse effect.

... Such complete restrictions prevent other related professions such as optical dispensing and orthoptics from providing some of the services at a lesser cost to the community."[28]

These organisations tended to support the title and core practice model recommended by the Clinical Issues Working Party with exemptions from the core practice restrictions in appropriate cases. The Royal Australian College of Ophthalmologists also supported this model, however a different view on the practices that should be restricted was provided:

"In our view it is hard on public health grounds to support the proposal that refraction and prescription of itself should be reserved for optometry. A wrong prescription for glasses will not of itself cause damage to adult patients, a fact reflected in the availability of off the shelf glasses.

"The position of contact lenses is less clear cut because of close proximity to the eyes along with the growing variety in fashion contact lenses. The College is inclined here to suggest that prescribing should be carried out by or under the supervision of an optometrist or registered medical practitioner. However, fitting could then be carried out independently by these groups or by an orthoptist or optician."[29]

The position of the Australian Optometric Association (NSW Branch) is less clear.

"The practice of optometry should be governed by restricting the title of "optometrist",

---

26 Submission from Mr Peter Freeman, Optometrist dated 13 August 1998 at page 2
27 Submission from the Council on the Ageing Inc dated 27 August 1998 at page 2
28 Submission from the Australian Dispensing Opticians Association dated 11 August 1999 at page 2.
29 Submission from Royal Australian College of Ophthalmologists dated 14 August 1999 at page2

"optician" and/or any other clinical title conferred by the Board to appropriately qualified optometrists and by basing the core competencies of optometry on an appropriate standard."[30]

The core competencies recommended by the OAA as the basis for the "core practice" restrictions cover the full range of optometric practices, in particular, professional assessment of the ocular adnexae, the eye and "symptoms found incidental to the ocular examination in relation to the patient's eye and/or general health". It is also includes the prescribing of spectacles, contact lenses, vision devices and pharmacological treatment regimes and the professional utilisation of diagnostic and therapeutic drugs for the treatment of eye diseases, management of patients requiring vision therapy and referral to medical specialists as required. The Association concludes "only qualified optometrists can and should perform any or all of the functions described above".[31]

No evidence of the risks of harm to consumers from restricting such a broad range of "core practices is provided, although the Association does highlight the benefits including:

- provides certainty to the public about competencies (approved by the Commonwealth Government) and qualifications and eliminates confusion about the role of optometrists;
- Prevents unqualified people from misleading or injuring the public ; and
- "Enhances competition in the provision of professional eye care services by removing the inappropriate monopoly of medicine over many aspects of medicine and over many aspects of primary eye care".[32]

The Association acknowledges the disadvantages in that it does not empower consumers to choose their own eye care provider, it does not provide for deregulation and there is continued Government involvement in the regulation of clinical optometry.

4.4 Results of the Economic Analysis by ACIL Consulting

ACIL Consulting conducted an economic appraisal of the options for regulation of the optometric profession pertaining to registration, restrictions on practice and ownership restrictions. In relation to registration and restrictions on practice, ACIL was asked to assess the options identified above, in particular to assess the costs and benefits of the different options.

While the options identified above were used by ACIL for the assessment, it should be noted that ACIL also included for assessment variants of **Option 6,** title and whole of practice restrictions with an exemption for orthoptists to prescribe glasses. Two specific sub-options were considered:

Option 6A: Orthoptists are not restricted in their prescription of glasses within their existing qualifications.

Option 6B: Orthoptists are not restricted in their prescription of glasses, however, they must first upgrade their qualifications.

For all options ACIL sought to quantify costs associated with administration, compliance costs for

30 Submission form the Optometrists Association Australia (NSW Branch) dated 10 August 1999 at page 13.
31 Submission form the Optometrists Association Australia (NSW Branch) dated 10 August 1999 at page 13.
32 Submission form the Optometrists Association Australia (NSW Branch) dated 10 August 1999 at page 14.

optometrists, disciplinary arrangements, and educational costs. ACIL was not able to quantify costs associated with increased health risks from the various options, although a qualitative assessment of these factors using a "threshold analysis" was carried out.

ACIL reached the following conclusions.

- There is little difference in terms of quantifiable costs (as identified above) across the various options, although options 1, 5, 6(a) and 7 were comparable in terms of quantifiable costs, with other options being slightly higher.
- Option 1 has the potential for significant competition cost savings for the consumer compared with Options 5 and 7; however, the public health risks of option 1 are of medium significance.
- Threshold analysis indicates that the public health risks associated with option 1 would only need to be valued at around 4% of the average consultation fee per service for them to result in a net cost to the community. This suggests that deregulated options 1 – 3 should be avoided.
- Option 6B under which orthoptists are required to upgrade their qualifications avoids any increase in health risk and has benefits from competition that more than offset any additional cost from education.

On this basis, ACIL concludes in the Report that Option 6B (Practice restriction with exemption for orthoptists who upgrade their qualifications) is the preferred option. However, ACIL suggests that the lack of available data and the indicative nature of the assessment procedures used should temper this conclusion.

4.5 The Department's Preferred Position

4.5.1 Options 1 to 3

The Department accepts the position expressed in the ACIL report and made in most submissions that **Options 1** to **3** should be avoided. As established in Chapter 3, there are risks from an unregulated market in that consumers lack the information to make informed choices regarding service providers. It is the Department's view that the potential exists for consumers in the market for optometrical services to be misled into believing they have had an optometric examination from a qualified person because of the variety of competing service providers. Further, technological changes in recent times, particularly with the development of auto-refractors, increase the potential for less qualified persons to offer services.

This could result in harm, for example financial costs through the wrong or inappropriate prescription of glasses, missed diagnosis, and physical injury (such as discomfort) from inappropriate prescription of glasses. Information costs would also be incurred by consumers to identify practitioners, although these would be reduced under **Options 2** and **3**.

There is significant doubt as to whether the prohibition on misleading and deceptive conduct contained in the *Trade Practices Act 1974 (Cth)* and the *Fair Trading Act (NSW)* would provide sufficient protection to consumers in the absence of any direct regulatory controls in the eye care market. While a consumer could clearly seek redress where a practitioner falsely claimed to hold qualifications, the provisions are unlikely to be effective in situations where qualifications are held but

are not of sufficient standard for the services the consumer is seeking.

While the *Health Care Complaints Act 1993* enables consumers to make a complaint about any health service provider, registered or not, little action can be taken where the person is not registered. While complaints could be referred to a professional association for action, professional associations often have a limited ability to take disciplinary action against their members. A recent Parliamentary Committee Inquiry into unregistered health professionals highlights the potential problems that can arise in the absence of statutory registration. While the Health Care Complaints Commission has the ability to deal with complaints, and professional associations can also play a role in this regard the Committee found that these arrangements could be inadequate to ensure that appropriate standards are maintained.[33]

Although the use of a co-regulatory model or self-regulation is theoretically possible in this environment because of the presence of a strong professional association which covers a substantial number of members, it is likely that the costs that would flow from deregulation in the terms of increased risk to public health and safety would outweigh any competitive market considerations, in light of the ACIL threshold analysis.

Further the costs currently borne by the administration of the current Act would simply shift to private associations, without any real savings for the community.

4.5.2 Option 4 - Title regulation

The Department supports a regulatory system based on title restrictions. While **Option 3**, voluntary certification with practitioners gaining the right to use a specific ‘accreditation symbol’ would have similar benefits, it is likely that competitors will develop other accreditation systems and consumers will incur costs in distinguishing between ‘appropriate’ systems. By contrast, the existence of a simple title, “optometrist” is a cost effective and easily understood mechanism through which consumers can identify qualified practitioners.

It is the Department’s view that a restriction on the title optometrist is likely to significantly contribute to the minimisation of risks in an unregulated market because consumers can make informed choices to seek the services of such practitioners.

It is important to note that the title ‘optician’ is also restricted by the current Act and optical dispensers have argued that they should be entitled to use this title, as is the case in other jurisdictions. While noted, the Department is concerned that deregulation may result in confusion for the community if individuals mistakenly believe the title continues to relate only to optometrists. The Department is unable to reach a final position on this issue at this time. It is therefore proposed that the restriction in the Act be replaced by a regulation making power that enables additional titles such as ‘optician’ to be prescribed by Regulation. Further consideration can be given to the issue of whether this title should continue to be restricted during development of Regulations.

---

33 Joint Committee on the Health Care Complaints Commission NSW Parliament, *Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints – Final Report* December 1998.

4.5.3 Options 5 – 7: Is there a case for restrictions on the practice of optometry?

The principal argument against practice restrictions is that they restrict the number of practitioners that can provide services. This could lead to higher prices because competition is limited. Further, the lack of competitive pressure reduces innovation and reduces the need for practitioners to make available information about the services that they provide consumers. In serious cases, practice restrictions can lead to a decline in quality of care and service, as there is no pressure on service providers to offer the full range of services.

However, as was stated in many submissions, the absence of such restrictions could result in incompetent service providers providing services, increasing the risk of injury or harm. The concerns regarding higher prices, reduced information to consumers and lower quality of care are usually countered by claims that 'professionalism' and registration prevent this from occurring by those seeking to retain practice restrictions.

It is impossible to determine whether practice restrictions contribute to higher prices for optometric consultations because of the predominance of bulk billing under Medicare (see section 2.8), although the costs of restrictions may be reflected in the cost of optical appliances (because of the fusion of prescribing and dispensing in the optometric profession) and consultation fees for the fitting of contact lenses.

Although some material has been provided by the OAA to suggest that costs for optical appliances are largely comparable between optical dispensers (who cannot engage in prescribing) and optometrists, it is difficult to draw conclusions from this material. The current restrictions may be affecting optical dispensers' ability to compete or achieve economies of scale. That is, because optometrists are the first point of contact when a patient seeks to purchase a new pair of glasses (and the optometrist is able to both prescribe and fill the prescription), they may have a high capture rate thus limiting the number of patients attending optical dispensers after obtaining a prescription.

Indeed the Competition Principles Agreement makes it clear that it is incumbent on those seeking to retain restrictions to establish that there are benefits that flow from those restrictions. Limited evidence has been presented to suggest that practice, particularly whole of practice, restrictions provide a greater level of protection than other forms of regulation such as a title restriction alone.

The Department is of the view that it is questionable what benefit that ***whole of practice restrictions*** as provided for in **Option 7** would have in protecting the public. Contrary to the commonly held view reflected in some submissions, medical practitioners do not have a practice restriction which reserves for them the full scope of medicine, such as surgery, diagnosis of disease, prescribing of medicines, recommendation of treatment and so on. The Medical Practice Act 1992 protects the title "medical practitioner", so that consumers can make an informed choice when seeking such services. The ability of unregistered persons to prescribe dangerous drugs, a 'core' practice, is limited by the Poisons and Therapeutic Goods Act 1966. No evidence has been presented which suggests the optometric profession warrants a higher level of regulation than that which exists for medical practitioners.

On the contrary, the Department's view that "whole of practice" restrictions fail to recognise the

changing roles of professional practice and have the potential to stifle development of new services by both optometrists and potential competitors. The complexity of the system under the current Act highlights this point. Although a broad definition of optometry is provided, numerous exemptions are granted to recognise the roles of other professionals.

The issue remains as to whether there are certain ***core practices*** that should be reserved to optometrists.

Contact lenses

The Department supports the view of the Royal Australian College of Ophthalmologists that there are risks in relation to the fitting of contact lenses that justify additional regulation, because of their close proximity to the eyes. The Board of Optometrical Registration has provided a substantial amount of literature to support the claim that the fitting or prescribing of contact lenses is a highly specialised process that requires training and experience. Incorrect or inappropriate prescribing of lenses could result in eye damage. Further, there is a need to monitor and supervise the initial use of such appliances through the prescribing process and it is critical that those instructing have an appropriate level of training so that they can ensure that the consumer understands the nature of the product.

Clearly, the potential adverse consequences arising from contact lens use can be serious with the potential for loss of sight. This material was considered by the Clinical Issues Working Party in making its recommendation that this practice be restricted.

Prescribing of glasses

The Clinical Issues Working Party also recommended that the prescribing of glasses be restricted. However, the Royal Australian College of Ophthalmologists has questioned whether there are risks from the incorrect prescribing of glasses to justify such a practice restriction. OPSM has drawn the Department's attention to a study from Britain by the Office of Fair Trading that concluded there are no significant risks of injury from an incorrect prescription for glasses. While this is noted, it should also be recognised there may be less significant financial costs or short-term discomfort that should be considered, as discussed in section 3.3. Clearly the Board and Department of Fair Trading have dealt with a number of cases where inappropriate prescription of glasses has resulted in cost, inconvenience and discomfort.

Indeed in deciding to make ready made spectacles more freely available to the public in 1996 through an amendment of the *Optical Dispensers Licensing Regulation* the Government implicitly recognised that the risks of injury from the wrong glasses themselves are not sufficient to justify the prohibition of supply of non-prescription glasses.

However, while these risks may not of themselves be sufficient to outweigh the costs of restricting competition, there is another important issue that requires consideration. It has been argued in submissions that the issuing of a prescription is a complex procedure that requires a full examination of the eye to detect other significant problems, not only with the eye. It is possible that with an auto-refraction machine, an unqualified person could carry out a simple refraction and fail to carry out a more comprehensive examination to detect other conditions or problems. In essence, an argument is made that there is a market information problem that needs to be addressed, namely, that consumers

expect to have a full eye examination and they are incapable of assessing whether that is being carried out.

It is important to distinguish the prescribing of glasses from the situation in relation to ready made-spectacles where no eye examination is carried out. The availability of ready-made spectacles has been found not to discourage consumers from seeking a full eye examination on a regular basis.[34]

Although it is difficult to quantify the benefits that such a requirement may deliver, an indicative assessment of the potential risks of undetected disease such as diabetes, highlights the potential benefits of such a restriction. There are an estimated 300 000 to 400 000 cases of undetected cases of eye disease in the community and optometrists look for signs and symptoms of diabetes.[35] By requiring individuals to seek a registered practitioner to have a prescription fulfilled, some cases may be detected minimising long-term health costs for the public and thus protecting a number of individuals from the significant risk of injury or harm.

The Optometrists Association has in the past claimed the following:

> *"In the course of routine eye examinations Australian Optometrists annually detect 16,100 previously undiagnosed patients with ocular signs of diabetes, 19,000 patients with glaucoma, 20,000 patients with cataract, 11,000 patients with vascular disease about 10,000 patients with other sight threatening diseases, and more than 6 out of 100 patients are referred to their general practitioner."*[36]

The Royal Australian College of Ophthalmologists has previously advised the Department that the accuracy of these figures may be questionable.[37] RACO suggests that the number of individuals with previously undiagnosed glaucoma attending an optometrist would be much lower, probably about 4,137 patients annually. In the case of diabetes in adults the figure is likely to be around 1,428 per year. Notwithstanding the disparity in the figures between the relevant professional association, it is clear that optometrists do play a role in detecting eye disease.

This was recognised also at the time of introducing the Optometrists Act 1930. At the time of introducing the Bill, the then Minister stated:

> *"A considerable knowledge of the science of optics is required to prescribe glasses, and this Bill is an attempt to ensure that they are capable of testing the eye sight and prescribing glasses shall be qualified to do so...*
>
> *... I am certainly prepared to admit that one comes across cases where failure in vision cannot be remedied to any extent by any lens which may be placed by the eye – cases where defective vision is due to some inherent disease in the eye itself."*

Although it is conceded that the cases where this may be the case are not substantial, nonetheless:

---

34 American Academy of Ophthalmology *Ready to Wear Reading Glasses*, 10 September 1988.
35 *Your Eyes* Vol 3 February 1998 at www.aio.com.au/
36 Australian Optometry Vol 16 Number 8 August 1995.
37 Letter to the Hon A Refshauge MP, Deputy Premier and Minister for Health dated 20 June 1995.

> *"I am also inclined to state from my experience that those men who have a scientific knowledge of optometry and who have received technical training in the matter, that most are prepared to recognised their limitations and, if they find they cannot bring about an improvement, are prepared to tell the persons consulting them that they can do nothing for them, and that it is their duty to consult with a medical man who has specialised in eye disease. The effect of such a measure as this will be to increase this practice."*[38]

In other words, it is the very act of prescribing that may create difficulties for consumers. The act of prescribing itself requires monitoring by a standards body to ensure that professions that claim to be able to assess eyes and prescribe glasses behave responsibly and refer practitioners on where they find another significant defect. This risk exists because those that prescribe also have the ability to fill the prescription and they may therefore be tempted to sacrifice quality in order to deliver a profit.

While there is merit in this argument, there is also a flaw. There is no guarantee that all registered practitioners carry out comprehensive eye examinations. The Optometric Association of Australia has provided material from overseas, primarily Britain and the United States, whereby consumers have visited registered practitioners that have failed to carry out a full eye examination and detect other pathology or eye conditions. [39] Indeed, an argument could be made that if unregistered practitioners could provide simple refraction, this would encourage registered optometrists to provide more information to consumers on the benefits of having a full eye examination possibly leading to improvements in eye-health overall.

However, it must also be recognised that those registered persons that do not carry out the full eye examination have a professional and legal obligation to inform the patient about the nature of the examination and or management that they are providing. If informed by the practitioner of the availability of a full eye examination, the consumer can elect to have the full treatment carried out. There is no guarantee that an unregulated professional group would exercise this responsibility and may exploit the imbalance of information.

It is recognised that a mandatory information disclosure requirement could be imposed on those unregistered persons who prescribe whereby they are required to disclose the nature of the examination they are performing. Indeed when purchasing ready made spectacles the consumer is made aware during the purchase that they are not receiving a full eye examination as the Optical Dispensers Licensing Regulation requires such a warning to be attached to the glasses. While this is effective when purchasing a "good", in a service relationship the personal relationship between consumer and practitioner is likely to undermine the effectiveness of such a mandatory warning. Further this would be difficult to enforce.

---

38 Hansard, Legislative Assembly 6 May 1930 at pp 4850 – 4851.

39 In particular see testimony from Robert R Nathan Associates Inc, Consulting Economists, in the Matter of Ophthalmic Practice Rules; Proposed Trade Regulation Rule (Eyeglasses II): Notice of Proposed Rule Making (50 Fed. Reg. 598, January 4 1985). This study compared the practices of practitioners working in private practice settings to those working in commercial settings where a slight variation in the ability of the two groups to detect complex eye problems because of differences in consultation times. This material was submitted by the OAA (NSW) to support its case for the retention of ownership restrictions. Its relevance to that debate is discussed latter in the paper.

On balance, it is the Department's view that a case can be made out that there are net benefits in placing a restriction on the prescribing of glasses, in addition to contact lenses, because of the risks to the community from unqualified persons carrying out such examinations as outlined above. While a title restriction alone could very well provide a substantial degree of protection, in light of the ACIL analysis, the benefits of increased competition from the removal of this restriction are likely to be outweighed by the increase in the risks to health and safety. In reaching its conclusion the Department notes that Victoria and Tasmania have completed the review of legislation in accordance with the Competition Principles Agreement and have decided to retain a restriction on the prescribing of glasses.

However, there is a need to ensure that this restriction does not unjustifiably restrict competition. This can be achieved by including a provision that enables other professional groups to be exempt by regulation in circumstances where they can establish they have sufficient competence or skill to engage in the core practice. As this would be done by regulation, such decisions would be made by Government based on advice from relevant bodies. An exemption provision such as this will ensure that competitive costs are minimised without leading to an increase in costs or injury for the community as a whole.

ACIL's preferred position was that a whole of practice restriction be retained with exemptions for orthoptists to upgrade their qualifications. ACIL did not consider the option whereby only the core practices of prescribing optical appliances are retained with an exemption for other professionals (such as orthoptists) provided they upgrade their qualifications to minimise any health risk. It is the Department's view, that the relevant benefits and costs for this option are likely to be broadly similar to the option preferred by ACIL, and in light of the advice of the CIWP, there is unlikely to be any significant increase in risk.

Legislative enactment of core practice restrictions

The retention of core practices restrictions raises a fundamental issue - should the core practice restrictions be enacted in legislation regulating the optometry profession, or should they (along with other core practices relating to other professions) be enacted in legislation dealing broadly with public health and safety. Currently, where practice or core practice restrictions are enacted, they tend to be placed within a health professional registration Act. However, the Department is of the view that this is no longer appropriate for the following reasons:

- In an environment where several professions may be able to carry out the procedure, it is questionable whether the restrictions should be placed in one Act regulating a particular profession.
- An approach consistent with that used for determining access to therapeutics (where such decisions are made under the Poisons and Therapeutic Goods Act 1966) should be adopted for 'dangerous' practices.
- Unregistered health practitioners are currently required to review a number of pieces of health legislation in order to determine what practices they should not engage in. Transfer of practice restrictions to a 'general' legislative enactment will provide such persons with a single point for determining the scope of their practice.

Recommendation 2 – Registration by Title

It is recommended that the Act:

- Provide for the establishment of a register of optometrists;
- Restrict use of the title 'optometrist' and other titles prescribed by regulation.

Recommendation 3 – "Optician"

It is recommended that in developing regulations under the Act, the Minister consider whether the title 'optician' should continue to be restricted by regulation.

Recommendation 4 – Core Practice Restrictions

It is recommended that the Public Health Act 1991 be amended to provide that only registered optometrists, medical practitioners and others exempted by that Act or regulations made under the Act may engage in the practice of prescribing glasses and the fitting of contact lenses.

4.6 Core Practice Restrictions – Exemptions for persons acting under the supervision of a registered optometrist or medical practitioner

The Clinical Issues Working Party recommended that individuals working under the supervision of registered medical practitioners or optometrists be exempt from the core practice restrictions. In the current regulatory environment, some submissions have suggested that refraction is often carried out under supervision of a medical practitioner or optometrist. Following an initial assessment by the supervising practitioner, another practitioner such as an orthoptist carries out refraction. After this refraction is carried out, the patient then returns to the supervising practitioner who issues the 'formal' prescription.

It is arguable whether this practice is strictly within the scope of the provisions of the current legislation. However, if this practice is widespread it does not appear to be exposing patients to unnecessary risks of harm or injury (presumably because referring practitioners select practitioners with sufficient skill and competence to undertake this task).

The Department is of the view that no evidence has been presented to suggest that refraction of itself is a dangerous practice. As highlighted by the Royal Australian College of Ophthalmologists, the prescription of glasses is unlikely to expose consumers to the risk of serious harm of injury. What is critical is that a qualified medical practitioner or optometrist has reviewed the patient in the first instance. The proposal, therefore, for individuals to be permitted to prescribe under supervision, as recommended by the Clinical Issues Working Party is considered appropriate.

Recommendation 5 – Exemption for Persons Acting Under Supervision

It is recommended that the Public Health Act provide an exemption from the core practices for individuals acting under the supervision or control of a registered optometrist or medical practitioner.

4.7 Core Practice Restrictions – Should orthoptists be exempt?

The Department's preferred model, as set out in recommendation 2, will remove significant restrictions contained in the current Act on the ability of orthoptists to practise. The issue remains however of whether orthoptists should be permitted to prescribe glasses or fit contact lenses. While, few submissions directly addressed this issue the relevant professional associations, the Optometrists Association and the Orthoptic Association of Australia, expressed clear and divergent views on the subject.

The principle objection raised by the optometric profession is that orthoptists are inadequately trained and lack the experience to practise as independent eye care practitioners. In particular, orthoptists are only trained to 'auto-refract' and cannot conduct a full examination and make an appropriate diagnosis of refractive errors, ocular disease and systemic disease. The Optometrists Association contends that orthoptic training is designed:

> *"…. to produce graduates who can work in hospitals and in the private practices of ophthalmologists to provide technical assistance to ophthalmologists who have responsibility for patients."*

Further, the Optometrists Association has made the following points in its submission.

- An assessment of the Victorian course curriculum highlights deficiencies in orthoptic training.
- The TER for the entry to the orthoptic course is significantly lower than for optometry.
- Most practitioners would not be able to upgrade their qualifications to a suitable standard (with many only holding two to three year degrees).
- Orthoptists currently have limited practical experience in conducting refraction and comprehensive eye examinations.
- The profession lacks an independent regulatory body to regulate the conduct of members.
- Consumers will receive a lower standard of care, possibly resulting in missed diagnosis and incorrect prescriptions, and resources will be wasted through inappropriate referrals.
- The public will be mislead and confused because of the difference in skill level of the two professional groups.
- Orthoptists will not receive Medicare benefits and will therefore have a lower level of community support.

The Orthoptic Association has made numerous detailed submissions to the Department over a number of years in relation to the restrictions on orthoptic practice contained in the current Act. The Association contends that although orthoptics once had a clearly defined role in relation to optometry - specialisation in the investigation and treatment of binocular vision and eye movement disorders - both optometry and orthoptics have developed and expanded their skills, and developed the rigour and content of their entry level educational requirements. The Association states:

> *"The lack of direct access to orthoptic treatment and the complex referral procedure which occurs as a result of requirements of the current Act, have many implications which include:*
>
> - *Patients who would benefit from direct access to an orthoptist are being seriously*

disadvantaged and are unable to exercise freedom in their choice of health care;

- *There is an increased cost to the patient, and indirectly to the community, due to the extra consultations prior to orthoptic intervention;*
- *There is a time delay in the initiation of orthoptic treatment resulting in extended personal discomfort, and/or delay in the rehabilitation process when particular vision problems can restrict general mobility and delay recovery generally;*
- *There can be secondary physical injury to the patient whilst waiting for orthoptic intervention, for example, in cases of double vision."*[40]

The Orthoptic Association argues that orthoptists have sufficient skills, training and experience to undertake a full range of diagnostic procedures, including determination of any refractive error. Many in fact undertake the task, but have another practitioner formalise the procedure.[41] Further, the Association questions whether refraction of itself is a highly specialised skill and the prescription of glasses can cause harm. While conceding that those who test eyes need to be aware of signs of eye disease, the Association argues that the current training and experience provided to orthoptists ensures that they are competent to undertake this task and prescribe glasses and contact lenses.[42]

In response to the criticisms of the Optometrists Association, the Orthoptic Association makes the following points.

- Orthoptic training has a strong basis in the basic biomedical sciences, over 336 hours academic training in the functioning of visual systems and substantial training in visual pathology.
- Orthoptists are not "technicians", but are highly educated practitioners with a high level of autonomy in professional practice.
- Graduates have been practising at a degree level since 1992 and currently comprise the majority of practitioners. Those with shorter qualifications have substantial practical experience that should be considered.
- The orthoptic profession is currently in the process of establishing a new self-regulatory body, independent of the Royal Australian College of Ophthalmologists.

The Department has made the following observations.

- The current Optometrists Act clearly inhibits the development of the orthoptic profession, and limits consumer health care choices.
- Although the letter of the current Optometrists Act prevents orthoptists from refracting, there is evidence to suggest that in practice this occurs under the supervision of other practitioners. No evidence has been provided suggesting that significant harm to consumers has resulted.
- It should be emphasised, however, that at present orthoptists do not see patients without the patient having first been assessed by another registered practitioner.
- Three complaints about orthoptists have been received in Victoria since orthoptic practice was partially deregulated in that State.[43] One prosecution has occurred. It would appear that the

---

40 Submission from the Orthoptic Association of Australia (NSW Branch) dated 12 August 1998 at page 4

41 As in footnote 21 at page 5.

42 As in footnote 21 at page 5.

43 Letter from the Optometrists Registration Board of Victoria to the NSW Minister for Health dated 9 September 1999.

prosecution related principally to the breach of statutory provisions in that state (that is orthoptists prescribing outside the permitted scope of the legislation) and does not relate to the quality of care provided.

On the basis of the material received, the Department is of the view that orthoptists have sufficient training and skill to engage in refraction for the purposes of issuing prescriptions for either contact lenses or glasses. Both the existing training offered, and the material provided concerning current practice suggests that they are competent professionals capable of engaging in the tasks of refraction and prescribing. At this point in time, the Department supports the inclusion of an exemption for orthoptists to engage in the core practices where the patient has been referred by a registered medical practitioner. In these circumstances, the patient would have been reviewed by a qualified practitioner who can assess the patient for any signs of eye disease or other systemic pathology.

That said the issue remains as to whether orthoptists should be permitted to refract and prescribe without patients having first been seen by another registered practitioner. As was noted above in section 4.5.3 the principal reason for restricting the prescribing of glasses is the concern regarding the diagnostic ability of unregistered professionals.

Although the absence of evidence of harm is highly relevant in determining whether orthoptists should be permitted to refract after the patient is seen by a registered practitioner, it is difficult to draw conclusions from this material on the issue of whether orthoptists have sufficient skill to diagnose eye disease and engage in a broader primary eye care role. Patients are first seen by a registered practitioner prior to prescribing who can detect eye disease.

However, if the argument that orthoptists have only limited exposure to refracting independently of another professional is to be given significant weight then their scope of practice could never expand. If the same principle were applied to optometrists, that profession would never have been given access to diagnostic drugs and could never get access to therapeutics.

The Department has however recognised the following significant points on this issue:

- Risks to the public are the most significant consideration in determining whether restrictions should be removed. As has been recommended in relation to optometric access to drugs, if orthoptic training is of a sufficient standard to minimise those risks, then existing restrictions should be reviewed. ACIL also concluded that if orthoptists are required to upgrade their qualifications to avoid any increase in health risk, benefits from competition will more than offset any additional cost from education.
- The assessment of the Victorian orthoptic course is of little significance to the current review. Similarly, TER scores are of no relevance given they primarily reflect supply and demand for specific courses. A detailed assessment needs to be made of the NSW orthoptic course to determine whether graduates have sufficient competence to prescribe optical appliances.
- On the basis of the material provided to the review to date, orthoptists do receive a substantial amount of training in basic sciences and in the assessment of ocular pathology (336 hours in total). It is the Department's view that current training could be upgraded, if necessary, to a sufficient standard to address public health concerns as set out in section 4.5.3.
- Further, orthoptists are currently required to undertake diagnostic tasks in relation to the eye and

clearly have practical experience in this regard.

The Department is not, at the current time, in a position to reach a final conclusion as to whether training is adequate for the purposes of diagnosing the full range of eye conditions prior to the conduct of refraction. Although it would appear that current training is extensive, a detailed analysis of curriculum and the existing regulatory structure for orthoptists needs to be made before they assume the role of a primary eye care provider.

The Department strongly supports further consideration being given to the issue of whether orthoptists should be entitled to treat patients in their own right, without first being reviewed by a medical practitioner. This remaining issue can be considered in the context of one of three forums:

- During drafting of the new legislation, although the level of analysis required in this regard is likely to hinder passage of the new legislation; or
- During development of exemption Regulations under the Public Health Act 1991; or
- By Australian Health Ministers Advisory Council in the context of an application from the orthoptic profession for registration by title which should be considered on a national level.

Recommendation 6 – Exemptions for Orthoptists

It is recommended that:

(a) Orthoptists be exempt from the core practices identified in recommendation 4 where a registered medical practitioner refers the patient to them.

(b) In developing Regulations under the Public Health Act 1991, consideration be given to including an exemption for orthoptists to enable them to treat patients in their own right.

4.8 Should Optical Dispensers Have an Exemption?

The Optical Dispensers Licensing Act 1963 contains restrictions on the ‘practice of optical dispensing’. This also comprises part of the current definition of the ‘practice of optometry’. Until such time as the Optical Dispensers Licensing Act 1963 is again reviewed, this restriction will remain in place under that Act with an exemption for registered optometrists.

An issue has also arisen during the review as to whether optical dispensers should have exemptions from core practices as recommended above. Two specific matters have been identified for consideration.

- The Australasian Dispensing Opticians Association have argued that optical dispensers should be permitted to carry out parts of the core practices under the supervision of a registered optometrist or medical practitioner. Such practices, or variations thereof, exist in other jurisdictions such as the United Kingdom and New Zealand. [44]

- The Australasian Dispensing Opticians Association have also argued that the definition of 'fitting'

44 Submission from the Australasian Dispensing Opticians Association dated 11 August 1998 at page 3

of contact lenses should not prevent optical dispensers from instructing people in the use of contact lenses, particularly the increasingly popular soft disposable contact lenses.[45]

Any reform in either area, is vigorously opposed by the optometric profession, in particular, the Board and the Optometrists Association of Australia.

> *"The Board considers optical dispensers to be technicians devoid of any useful knowledge of anatomy, physiology and pathology, and it is in the public interest that their current role should not be changed."*[46]

These comments, and similar statements made by the Optometrists Association Australia (NSW Branch), have attracted significant criticism from the Optical Dispensers Licensing Board, the Australasian Dispensing Opticians Association, and optical dispensing training institutions namely, the Open Training and Education Network of TAFE and the Sydney Institute of Technology.

Acting under supervision

This issue is addressed by recommendation 5.

Placing a lens in a person's eye

It is the Department's view that the current Act does not prohibit optical dispensers from placing a lens in a person's eye. The perceived 'prohibition' would appear to have arisen from practice rather than the provisions of the Act. While the provisions of the Act clearly prohibit the "fitting of contact lenses" by unregistered persons, this cannot extend to placing a lens on a person's eye. If such an interpretation were favoured, the absurd situation would arise whereby an individual would be prohibited from placing their own lens in their own eye.

This raises a further issue, namely, whether legislation should prohibit optical dispensers from assisting a patient in the insertion and use of lenses. The Department is of the view that there is no clear rationale for prohibiting optical dispensers placing a lens in the eye particularly given they have substantially more training than the patient at the time of purchase.

---

45 Ibid at page 3

46 Submission from the Board of Optometrical Registration dated 12 August 1999 at page 4.

5. ACCESS TO THERAPEUTIC DRUGS

5.1 Introduction

The current Optometrists Act permits optometrists to use diagnostic drugs in the course of their practice where they hold a certificate from the Board. The diagnostic drugs that may be used are prescribed by the Act and Regulations. However, optometrists are not permitted to use drugs for any therapeutic purpose. The introduction of new legislation to regulate the optometry profession has been impeded for a number of years by an inter-professional dispute over whether optometrists should be given access to therapeutic drugs.

Optometrists have argued that they should be given access to a limited range of ocular therapeutics to facilitate an expanded primary eye care role. The medical profession, particularly ophthalmologists, have strongly resisted such moves arguing that optometrists are inadequately trained to carry out a therapeutic role and that patients will be exposed to significant risk of injury.

The Clinical Issues Working Party established by the Minister specifically considered whether optometrists should have access to drugs for the purposes of treating minor anterior eye conditions. Although consensus on the issue of whether optometrists' current training is adequate was not reached, a number of recommendations were made:

- If optometrists are to be given access to pharmaceuticals for treating minor anterior eye conditions, it is unnecessary to seek to define what is involved in treatment of the eye. Such a role should be delineated by the drugs to which optometrists are given access rather than through a definition of treatment.

- Access to therapeutics should be determined within the context of the *Poisons and Therapeutic Goods Act 1966* and optometrists should not be prevented from administering or recommending therapeutic preparations contained in Schedule 2 and 3 of the *Poisons and Therapeutic Goods Act 1966*.

- Optometrists should only be permitted to prescribe Schedule 4 preparations if it can be demonstrated that optometrists have sufficient training and skill in eye care and systemic disease, particularly the ability to diagnose eye conditions.

5.2 The Department's Draft Position on Access to Therapeutics

After considering the working party's report the Department in the Issues Paper put forward the following proposal for amendments to the Optometrists Act 1930 and Poisons and Therapeutic Goods Act 1966:

- Restrictions on the use of drugs in the Optometrists Act 1930 would be removed so that decisions regarding access are regulated through the Poisons and Therapeutic Goods Act 1966, as is the case for all other health professionals.

- Optometrists would continue to be authorised to use diagnostic drugs in the course of their

practices. Certification would no longer be required under the Optometrists Act as the required training has been incorporated at under-graduate level.

- A process for the certification of optometrists to use or prescribe therapeutic S4 drugs would be established in the new Optometrists Act. To obtain certification, practitioners would be required to hold qualifications at an appropriate level prescribed by the Regulations.

- The Poisons and Therapeutic Goods Act would be amended to enable certified optometrists to prescribe therapeutic topical S4 preparations that were approved by the Minister. The Minister would approve the medications after taking appropriate clinical advice.

Submissions on this draft proposal were invited.

5.3 Submissions

The Board of Optometrical Registration, the Nurses Association and South Eastern Sydney Area Health Service support the proposal put forward by the Department. Although supported by the Health Funds Association, it is noted that a prescription issued by an optometrist may not be covered under the PBS scheme and that this could result in the cost being shifted from the Commonwealth subsidised arrangements directly to patients.

The Optometrists Association of Australia also strongly supports the proposal put forward by the Department, however, the Association has recommended that:

- The arrangements for certification of practitioners should be set out in the Regulations and not the Act.
- The Act should establish a defined process for the review and approval of therapeutic drugs for use by optometrists and this process should have a definite time frame for completion.
- The actual regulation of which therapeutic drugs should be available to optometrists should occur through the Poisons and Therapeutic Goods Act and Regulations - not the Optometrists Act.
- Training should be specified by Regulation and not in the principal Act.
- The Regulations that establish the certification process need to include an appeal where there is disagreement with the certification body.
- Optometrists should continue to have access to the full range of diagnostic drugs they currently have.[47]

The Association has also provided an extensive list of pharmaceutical agents that it considers appropriate for use by certified optometrists.

The Royal Australian College of General Practitioners does not support broadening the role of optometrists to allow them to use pharmacological substances:

> *"Both the adverse effects of and interactions between drugs are constant problems. It must be recognised that a significant percentage of patients seeking eye care are elderly and may*

47 Submission from the Optometrists Association Australia (NSW Branch) dated 10 August 1999 at page 3

not be aware of the nature of their usual medication. The general practitioner is the only one with the complete picture.'[48]

The Royal Australian College of Ophthalmologists note that they have long argued against giving optometrists the right to use drugs on the basis that optometric training does not sufficiently equip optometrists to identify abnormal conditions and recommend appropriate treatment options. The College states:

"The College would prefer to retain its current position. However we accept that this may no longer be tenable in a practical sense.

"Deregulatory moves in certain states have already given optometrists limited prescribing rights. Given the College's core mission, we have no choice to be come involved in those states in discussions about the extent of prescribing rights and the training and treatment protocols to be associated with those rights. This then creates a presentational problem for the College in opposing prescribing rights in another jurisdiction."[49]

After considering the above matters the College has expressed support for the Department's proposal that restrictions on the use of drugs be removed from the Optometrists Act 1930. Further, the College supports the removal of certification requirements for the use of diagnostic drugs from the Optometrists Act on the condition that particular training is certified as giving optometrists the skills required to use diagnostic drugs. The College also supports the establishment of a process for the certification of optometrists to use therapeutic agents subject to the following.

"We suggest the issue of just what drugs might be prescribed should be left to a later point. At this stage, our focus should be on general principles. In this regard, we would suggest that the grant of prescribing rights should be based on:

- *Agreement on the drugs to be covered. The College would wish to play an active role in discussions in this area,*
- *The specification of appropriate training,*
- *The development, where appropriate, of practice guidelines whose application should be mandatory.*

Taken together, these restrictions should ensure patient safety, while broadening the roles of optometrists in the newly deregulated environment."[50]

The College has suggested a two-tiered approach to the use of drugs. Under the first tier, optometrists would be permitted to use diagnostic drugs (S2, S3 and S4) and therapeutic S2 and S3 drugs in the course of their practice after current undergraduate training has been assessed as adequate. Tier two would involve prescription of a limited range of S4 drugs after post-graduate training of a sufficient standard has been considered. In the event of transfer of S4 drugs to S2 or S3 the post-graduate requirements should continue to apply.

48 Submission from the Royal Australian College of General Practitioners dated 21 August 1998 at page 2
49 Submission from the Royal Australian College of Ophthalmologists dated 14 August 1998 at page 3
50 Submission from the Royal Australian College of Ophthalmologists dated 14 August 1998 at page 4

5.4 Conclusions

The Department remains of the view that optometrists should be entitled to prescribe or administer appropriate S4 therapeutic agents if it can be demonstrated that training is of an appropriate standard. This has the potential to deliver substantial benefits to the community in terms of improved access and reduced inconvenience. At this time, the Department accepts that under-graduate training may not be sufficient to permit prescribing of a wide range of therapeutic S4 drugs, however, the additional training can be made available through additional post-graduate training. The degree of additional training will be dependant on the nature of the drugs made available.

The Department therefore recommends that its draft proposal be adopted, although the following points raised in submissions should be noted.

Undergraduate training

In order for optometrists to gain access to diagnostic drugs and S2 and S3 therapeutic drugs, regulations need to be made under the Poisons and Therapeutic Goods Act 1966 so that optometrists can be supplied with the drugs by wholesalers of therapeutic goods. The Department is satisfied that undergraduate training in Australia is adequate to permit continued use of diagnostic drugs and to permit access to therapeutic S2 and S3 drugs for use in the course of the optometric practice. It is therefore unnecessary for an additional certification requirement to remain, however, it is apparent that some practitioners (particularly those trained overseas) may not have sufficient training or competence to use diagnostic drugs. For such practitioners, the Board will have the power to impose conditions on their registration to prohibit them from using drugs if the training is not adequate.

Further assessment of appropriate drugs and training requirements

The Department has proposed that the S4 therapeutic drugs permitted to be prescribed by optometrists will be determined by the Minister. Similarly, the training requirements are required to be prescribed by regulation.

The Department has reviewed its position in relation to the approval of drugs for use by optometrists. While it was originally proposed that the Minister would approve these drugs, the Department is of the view that such decisions should be made in accordance with the provisions of the Subordinate Legislation Act 1989. Under this Act, the relative advantages and disadvantages of granting access to specific drugs would be canvassed through a publicly available regulatory impact statement and draft Regulation. This approach is consistent with the current arrangements for making diagnostic drugs available to optometrists, which are required to be prescribed under Appendix E of the Poisons and Therapeutic Goods Regulation 1996.

Such decisions are complex and it is essential that the Minister has access to appropriate clinical advice during development. Naturally this would need to include advice from both the medical profession, given its experience in the use of therapeutic drugs, and optometric profession. This would be done in close consultation with relevant professional and advisory bodies. By ensuring that decisions regarding the accessibility of drugs are made in accordance with the Subordinate Legislation

Act 1989, consultation with key stakeholders and the community at large will become mandatory.

The Department does not support the proposal of the OAA (NSW Branch) that a timeframe be placed on the development of the regulations. It is the Department's view that imposition of an arbitrary timeframe on the identification of appropriate training requirements could result in overly hasty consideration being given to the matter. Clearly this is not appropriate where issues of public health and safety are involved.

Clinical practice guidelines

In some cases it may be appropriate for clinical practice guidelines to be developed to provide guidance to optometrists on the prescribing of therapeutic drugs. It is recommended that the legislation provide that as a condition of accreditation to prescribe, optometrists must comply with clinical practice guidelines (if any) approved by the Minister.

Recommendation 7 – Access to Drugs

It is recommended that:

(i) The restrictions on the use of drugs in the Optometrists Act 1930 be removed.

(ii) Optometrists be permitted to use diagnostic drugs (S2, S3 and S4) and therapeutic S2 and S3 drugs prescribed in Appendix E of the Poisons and Therapeutic Goods Regulations in the course of their practice unless restricted from doing so as a condition of registration.

(iii) The Poisons and Therapeutic Goods Act be amended to enable optometrists with prescribed post-graduate qualifications to use and prescribe those therapeutic topical S4 preparations prescribed under the Poisons and Therapeutic Goods Regulation 1996.

(iv) Those practitioners entitled to use and prescribe therapeutic agents must, as a condition of the entitlement, comply with clinical practice guidelines (if any) approved by the Minister.

(v) The Minister consult with the Optometric Association of Australia, the Board of Optometrical Registration, the Royal Australian College of Ophthalmologists and other appropriate bodies in prescribing training and therapeutic substances for use by optometrists who may prescribe and use therapeutics.

6. RESTRICTIONS ON OWNERSHIP OF PRACTICES

6.1 Introduction

Section 35 of the Optometrists Act provides:

"Except as provided by subsection (2), or with the approval of the Minister in writing, no firm or company or other person not being a registered optometrist shall carry on the business of the practice of optometry."

Subsection (2) provides that firms or companies that were carrying on such a business at the time the restriction was introduced in 1945 could continue to carry on that business at the same premises (or at premises within 8 km), or at other premises with the approval of the Minister.

The approval of new persons operating such businesses by the Minister was prohibited outright from 1969. While existing companies could continue to seek the Minister's approval to operate at new premises, this has since 1963 been subject to the condition that the Board must recommend to the Minister that such an approval be granted.

In any case where a firm or company carries out optometry, that practice must operate under the personal supervision and control of a registered optometrist.

The rationale for these restrictions is concisely set out in the Minister's Second Reading Speech at the time the legislation was introduced.

> *"It has been represented to me that in commercialised practice of the profession of optometry salesmanship takes precedence over both diagnostic ability and what should be the predominant feature in any profession, viz, the giving of service by the profession."*

And later:

> *"Furthermore, the Government is not prepared to be a party to a wealthy company setting up a chain of shops, resulting in the squeezing out of the individual. This provision is considered necessary to protect the bona fide individual optometrist, who may under an extension of the present system of corporate practice, be forced out of business by the big companies".*

However, it was noted in the Issues Paper that such restrictions have the potential to restrict competition, possibly resulting in higher prices for consumers and a decline in the quality of services provided. Submissions were sought as to whether these restrictions should be retained, and if so, whether their retention is consistent with the Competition Principles Agreement. These restrictions have been highlighted as potentially anti-competitive by the Commonwealth Industry Commission in its assessment of the potential benefits flowing from the full implementation of National Competition Policy.[51]

---

51 Industry Commission, *The Growth and Revenue Implications of Hilmer and Related Reforms: A Report by the Industry Commission to the Council of Australian Governments,* March 1995.

6.2 The Potential Impact of Ownership Restrictions

The restrictions outlined above, (the "ownership restrictions"), have been the subject of a number of reviews both within Australia and overseas.

Reviews in the United States - Federal Trade Commission

There has been a vigorous debate in the Untied States, principally involving the **Federal Trade Commission (FTC)**, concerning the impact of ownership restrictions. A review paper found that in 1977, commercial practice restrictions appear to have increased the price of an eye examination and optical appliances by at least 5 - 13%, without any apparent impact on quality.[52] Four identified commercial practice restrictions were found to inhibit optometrists' ability to realise economies of scale and prevent non-optometrists from realising economies of scale in the US. The four restrictions are a prohibition on employment of registered optometrists by non-optometrists, a prohibition on operating from premises where other businesses are conducted, restrictions on branch offices, and prohibitions on optometrists practising in a name other than their own.[53]

A further study by the US Bureau of Consumer Protection and Economics compared the price and quality of cosmetic contact lens fitting services of commercial optometrists and other provider groups. The report concluded that, on average "commercial" optometrists (for example, optometrists who were associated with chain optical firms, used trade names, or practiced in commercial locations) fitted cosmetic contact lenses at least as well as other fitters, but charged significantly lower prices.[54] The FTC also conducted a rule-making exercise during the 1980's and concluded, based on evidence assembled during the proceedings, that commercial restrictions resulted in "significant commercial injury, in the form of monetary losses and less frequent vision care, without providing consumer benefit", and that a substantial portion of costs for eyewear and examinations was attributable to inefficiencies attributable to an industry protected from competition.[55] A rule was made by the FTC to strike down such restrictions, however, the rule was overturned on appeal on the basis the FTC lacked jurisdiction to make the rule, however, the FTC argues that the substantive findings of the Commission were unaffected by this decision.

Reviews in Australia - Industry Commission

As noted above, the **Industry Commission** considered the impacts of preventing optical dispensers from being able to prescribe optical appliances and limits on one-stop shopping. The IC estimated that operating costs would fall by about $10 000 per dispensary through co-location based on United States data. [56] However, the IC research is of little benefit given that it does not appear to have taken

---

52 Haas-Wilson D, *The Effect of Commercial Practice Restrictions: The Case of Optometry*, 29 Journal of Law and Economics 165 at 183.

53 Ibid at page 183.

54 Bureaus of Consumer Protection and Economics, Federal Trade Commission, *A Comparative Analysis of Cosmetic Lens Fitting by Ophthalmologists, Optometrists and Opticians* (1983)

55 Letter from Christian White, Acting Director, Bureau of Consumer Protection, US Federal Trade Commission to The Hon G A Merit, Kansas House of Representatives dated 10 February 1995, available at *http://www.ftc.gov/be/v950004.htm*.

56 Industry Commission, *The Growth and Revenue Implications of Hilmer and Related Reforms: A Report by the Industry Commission to the Council of Australian Governments,* March 1995.

into account the current situation in NSW, namely that only two of the “commercial practice” restrictions considered in the US are in place, namely the trade name restriction and the prohibition on employment. Co-location of optometric and optical dispensing practices is permitted by the Act, and many optical dispensing businesses in recent years have entered into arrangements with registered optometrists to operate a practice from the same location (approximately 25-30%). Any estimate of the cost of such restrictions in NSW, based on the US reviews identified above, would have to be made at the lower range, namely around 5%.

The Department is not aware of any other reviews that have assessed the impact of ownership restrictions in Australia on price and quality of optometric services. Given the varied position among States and Territories in relation to ownership restrictions (NSW, Tasmania and Queensland remain the only States where non-optometrists are prohibited from owning optometric practices), a comparative analysis could potentially reveal the impact on price of restrictions.

Victoria - The Zifcak Inquiry

In May 1987, the Victorian Government established an independent review to consider a range of issues relating to the Board and optometric profession. Of particular interest to that review were emerging relationships between optical dispensers and optometrists, with an increased potential for "entrepreneurial practice".[57] The review was designed to consider the potential risks that may flow to the community from: the vertical integration of the prescribing and supply of optical appliances; pressure of commercial imperatives over-riding issues of patient care and mis-allocation of public funds through the potential for over-servicing.

This review focussed on two types of 'commercial' practices - "dispenser-hosted optometrists" whereby an optometric practice is established within a non-optometrist owned dispensing outlet and "optometrist owned dispensers". The later category exists where either an optometrist wholly owns a dispensing business and adopts aggressive marketing techniques or where optical dispensing companies buy into an optometric practice. (At that time optical dispensers could purchase up to one third of an optometric business).

Zifcak specifically notes that his Report does not look into traditional practice structures, notwithstanding that the potential risks to consumers also existed in those arrangements because of the vertical integration of dispensing and prescribing. The argument generally advanced, however, is that in these arrangements the risks to consumers of over-servicing and lower standards of care are not actualised because of the "ethical commitment of professional to client".[58]

The Inquiry made the following findings on the basis of evidence received.

(i) Where optical dispensers have purchased an interest in optometric practices or there are dispenser hosted optometric practices, pressure has been brought to bear to encourage optical aids to be prescribed more frequently and use products with a higher return. Alternatively, products that do not form part of the current inventory have been discouraged.

57 Zifcak, S, *Inquiry into Issues Affecting the Optometrical Profession: Final Report to the Minister for Health*, 1987 at page 57
58 Ibid at p 55

(ii) Optometric practitioners working where a dispenser has purchased an interest in the optometric business have either voluntarily or, due to pressure from the dispensing business tended to concentrate on high volume, low difficulty cases at the expense of those with chronic or complex conditions.
(iii) Confidentiality of client records remains unclear in cases where an optometrist has entered into an arrangement with a dispenser, particularly where the relationship is subsequently terminated.
(iv) Evidence of "bait and switch" advertising (where a consumer is attracted by one product but is then advised the product is unsuitable) was found in some commercial practices.
(v) Consulting optometrists have been provided with favourable leasing or other administrative arrangements on the implicit understanding that they will refer clients to the dispenser providing the benefit.
(vi) Small variations in the dispensing of an appliance from the patient's actual clinical requirements were detected on occasion.
(vii) Returned (used) contact lenses have on occasion been sterilised and resold.
(viii) Consumers have been directed to undergo an eye examination where they have presented with a current prescription.
(ix) In some commercially orientated practices, the time taken for an examination has been less than that which might be expected. By implication, this examination may not have been as thorough.
(x) Services provided on a travelling basis have been provided in less than satisfactory conditions.
(xi) Commercially orientated practices tend to have exceeded the number of consultations, which might on average be anticipated. However, Zifcak only accepts this evidence on a heavily qualified basis.

Notwithstanding the potential benefits which flow from co-location of facilities and the introduction of price competition from dispensing chains, the Report concludes that the potential for abuse exists and that there should be some form of structural separation. The Report states that:

> *"...the evidence is sufficient, in my view, to indicate entrepreneurial forms of optometrical practice require controls in the public interest. Although the problems to which controls should be directed are not now widely prevalent, without intervention at this point this may well become so."*[59]

A range of recommendations are made to achieve a degree of separation between optometric and dispensing practices including:

- A prohibition on optometrists purchasing an interest in a dispensing business not located on the same premises.
- Introduction of a requirement for the mandatory release of prescriptions.
- The prescribing of standards for premises.
- Increased powers to investigate over-servicing following referrals from Medicare and the introduction of peer review.
- A prohibition on dispensers and optical suppliers purchasing an interest in a practice.

59 Ibid at page 63.

The Victorian Government has since conducted a further review of the restrictions on ownership and has found that ownership restrictions do not produce an overall net public benefit in accordance with the Competition Principles Agreement. Accordingly, the recommended prohibitions on cross ownership have not been implemented in Victoria.

6.3 Results of the Economic Analysis Conducted by ACIL Consulting

As noted previously, the Department commissioned an independent consultant to consider options for the regulation of optometrists, including whether restrictions on ownership should be retained. ACIL concluded that it was extremely difficult to consider the ownership restrictions in isolation from the provisions that might exist in relation to registration and practice restrictions.[60] ACIL made the following observations in its Report:

> "• *Limitation of ownership is a blunt instrument in regards to impacts which can be dealt with under practice regulatory options. Public health risk impacts are more properly dealt with under the practice provisions of the regulatory options.*
> - *Under all practice regulation options, disciplinary process will be in place to deal with any trade-offs between commercial incentives and professional practice standards.*
> - *Under [a fully deregulated option where ownership restrictions are removed completely], there should still be incentives for professional standards to be upheld, assuming that the provisions under Options 1 to 7 (relating to registration) effectively prevent increased health risks in the practice of optometry. Consumer choice can provide incentives for efficient and, more importantly, effective service (ie at lowest cost to maintain professional standards), irrespective of the ownership system.*
> - *If deregulated ownership is deemed not politically acceptable , a provision for ownership could be incorporated - such as required share of practice which should be owned by optometrists (as in Queensland and Tasmania. Other jurisdictions other than these and NSW are deregulated in regards to ownership).*[61]

In conclusion:

> *"On balance, this analysis concludes that the risks of deregulated ownership are likely to be outweighed by the benefits to the consumers, given that a regulatory system continues on the practice of optometry".*[62]

6.4 Submissions

New Children's Hospital, the Royal Australian College of Ophthalmologists, OPSM, NSW Health Funds Association, MBF, Australasian Dispensing Opticians Association, South Eastern Sydney Area Health Service, a member of the Physiotherapists Registration Board and the Optical Dispensers Licensing Board support the removal of restrictions on ownership of optometric businesses.

---

60 ACIL Consulting Pty Ltd *Regulatory Options for the NSW Optometric Industry - Economic Evaluation - A Report for the NSW Department of Health* 1998 at page 39.

61 Ibid at page 39

62 Ibid at page 40

OPSM in a detailed submission makes the following arguments:

- There is no independent factual evidence from other jurisdictions to suggest that a commercially owned practice is any more likely to let professional standards slip than one owned by a non-commercial optometrist.
- Ownership restrictions result in economic 'disbenefits' with no resulting benefits to the community. Removal of the restrictions will produce public benefits. Deregulation of the ownership of medical practices brought with it a wider range of services.
- Optometrists derive 80% of their income from dispensing. The ownership restriction provides them with a significant competitive advantage in that they have a high chance of filling the prescription that they write.
- Unrestricted ownership is allowed for all other professions with the exception of pharmacists and dentists.
- OPSM employs a substantial number of optometrists in other states and has commercial arrangements. Similarly it has arrangements in NSW with a number of practitioners. There is no difference in complaint levels against optometrists generally and those "engaged" by OPSM.
- Deregulation of ownership would remove the commercial advantage that optometrists have in that they can fill the prescription that they issue.
- Optometrists employed by OPSM are encouraged to undertake continuing education. Further, it has in place a peer review process to review decisions on a case-by-case basis and an extensive customer satisfaction survey process which ensure that high standards are maintained.
- The standard of delivery is maintained, not by restricting ownership, but through setting high standards of training and supervision by the Board of Optometrical Registration.

MBF Ltd point out that:

> *"There is currently a significant business incentive in place for the optometrist to provide as many clients as possible with frames and lenses and it is not considered that this risk is magnified in loosening ownership restrictions. In fact, the added accountability that results in a non-optometrist owning the business may be positive, loosening the clinical mystique around the prescription of frames and lenses."*[63]

The Optometrists Association of Australia has argued vigorously that the ownership restrictions should be retained in their current form. The main points in this submission are:

- Optical dispensing and optometry are distinct. Optical dispensers have no clinical involvement with patients.
- There is already vigorous competition for both clinical services and the provision of eyewear and optical appliances. Fees compare favourably with those charged in other states, while ensuring high quality care is provided. There are no significant impediments to entry to the dispensing market.
- Pharmacy and medicine are clearly separated to minimise the potential for over-servicing. Similar principles should apply for optical dispensing and optometry.
- Deregulation is unlikely to produce any savings in relation to consultations because most are bulk-

63 Submission from MBF Ltd dated 17 August 1998 at page 3

billed through Medicare.

- Competition will be reduced because the high number of independent practitioners will be reduced as practices are rationalised.
- Optometrists have a responsibility to ensure that consumers are aware that they are entitled to their prescription.
- The Zifcak Inquiry provides evidence of inappropriate practices affecting patient care where commercial arrangements are made between dispensers and optometrists. Similar evidence can be found in a recent Board professional conduct hearing in NSW, and recent media reports concerning standards in commercially run medical practices.
- Sworn testimony in the FTC Ophthalmic Rule-Making cases in the US suggests that patient care will be compromised from the setting of targets, shorter consultation times and remuneration determined by patients seen. Similar material is provided from the United Kingdom suggesting that practitioners in commercial practices defer seeing more complex cases.
- Retention of restrictions ensures that owners understand the nature of practice and that they are directly accountable for their own conduct. This will prevent pressure being brought to bear to maximise returns to shareholders by decreasing consultation times and maximising throughput. In an unregulated environment, corporate owners can seek shelter behind the corporate veil and would not suffer any penalty if a practitioner is sanctioned or deregistered.
- Ownership restrictions ensure continuity of care.
- Removal of ownership restrictions would impact adversely on regional and rural NSW. There are currently major optical dispensing outlets in regional centres but not in smaller towns where independent optometrists predominate. Analogies are drawn in the submission between optometry and the banking industry in relation to the likely impact, that is the removal of ownership restrictions will result in rationalisation of the industry to major regional centres as smaller independent optometrists are forced to close because they cannot compete. Further by purchasing practices, competition is decreased because these practices no longer compete in the dispensing market against each other, as they now compete against each other.

The Board of Optometrical Registration supports reform of the existing provisions to provide for limited incorporation whereby optometrists can incorporate their practices, but other companies may not provide services. The Board argues:

> *"On the information available to the Board there are large optical dispensing corporations interested in increasing their involvement in the provision of optometrical services in NSW. As noted above, the profession of "optometry" is unique in that the practice of optometry encompasses optical dispensing. The Board's concern is that large commercial operations may be in a position of inappropriately dictating to service providers in their employ."*

And later:

> *"The Board is concerned that a significant increase of ownership by the dominant forces in optical dispensing will lead to a decrease in competition, especially in the geographical coverage of the profession."*[64]

64 Submission from the Board of Optometrical Registration dated 12 August 1998 at page 5.

A similar point is made by the Council on the Ageing (COTA) who, although not opposing deregulation, highlight some concerns:

> *"Our basic premise is that in any changes to the present system of ownership of optometrical practices, quality and safety of care, professional standards and consumer protection must not be jeopardised or compromised. In addition, as previously stated, we would be concerned if access to services were effected.*
>
> *"If loosening of restrictions on ownership in the name of opening up competition led to takeovers of individually owned optometrical businesses by large companies, this would enable concentration of ownership; which in effect could lead to fewer competitors in the market. In some centres it could lead to a monopoly situation, or rationalisations of outlets within a district/region, leaving no optometric service at all in some localities where presently there is one. This may mean further distances for older people to travel and likely higher transport costs. We would be concerned with any further erosion of health infrastructure and services to older consumers in regional and remote areas."*[65]

The Health Care Complaints Commission did not support one option over another, except to say that there is an accompanying need for compulsory registration of individuals if deregulation is pursued to ensure high professional standards are maintained.

6.5 The Department's Position

In order for the current restrictions to be retained it must be established that the benefits arising from the restrictions as a whole outweigh the costs, and that the objectives of the legislation (maintenance of public health and safety) can only be achieved by restricting competition.

The Department has, after considering the available material reached the following conclusions.

6.5.1 Evidence concerning the risks of harm to consumers from ownership of commercial practices by non-optometrists

Substantial material has been presented to the Department by the optometric profession concerning the risks that may arise for consumers if the ownership restrictions were removed. The Department has reached the following conclusions in relation to that material.

The Zifcak Report

Although based largely on anecdotal evidence, the **Zifcak Report** provides some evidence of 'harm' that may arise to consumers in situations where the professional obligations of optometrists are overridden by commercial considerations. However, two points should be noted:

- First, the Report found little evidence to suggest that this results in significant physical harm for consumers even in situations where shorter consultation times were found. Harm is primarily of a financial nature.

65 Submission from the Council on the Aging dated 27 August 1998 at page 2.

- Secondly, the Report only considered 'commercially orientated' practices and did not consider traditional optometrist owned and controlled practices because the conduct of these practices was outside the terms of reference for the Review. The Report clearly notes that the potential for a conflict of interest to arise (with the risk of injury or harm) also exists in these practices.

The Department is of the view that the Zifcak Report provides some evidence of financial harm arising in situations where professional obligations have over-ridden commercial consideration, however, it is important to stress that this has arisen in both "commercially operated" optometrist owned practices and non-optometrist owned practices.

Rather than establishing a case to exclude non-optometrists from the market completely, as was recommended by Zifcak, it is the Department's view there is a need for closer scrutiny of all types of optometric business because of the inherent conflict of interest that arises because the prescriber of appliances is also a supplier or dispenser. The registration system itself should assist in ensuring that inappropriate conduct does not occur on the part of registered practitioners because it gives an assurance to consumers that practitioners will and should operate in a professional manner. However, the argument remains that instances may arise where those obligations are sacrificed because of pressure from an employer who is not bound by the professional registration system.

Evidence from the United States

The Department has available to it conflicting evidence from the United States concerning the risks of injury to patients. The optometric profession has relied on evidence presented to the Federal Trade Commission, the Gunn Report, to establish that optometrists employed in non-optometrists owned practices failed to detect certain types of eye pathology. However, the FTC has advised the Department that this evidence was rejected by the FTC during the rule making process referred to above. Based on various other studies, the FTC concluded that removal of commercial practice restrictions would not pose significant risks to consumers. Although the rule-making process was overturned on appeal for lack of jurisdiction, the FTC argues its substantive findings were not challenged.

The Optometrists Association has also provided testimony given by a former proprietor of a commercial optometry firm in a Texas administrative law case *Rogers v Friedman* from 1976. The Department has been unable to determine what weight was given to this evidence during the proceedings and is reluctant to draw conclusions from this material.

Evidence from the United Kingdom

The Department's attention has also been drawn to a study by Professor G M Dunn in the United Kingdom by the Optometric Association. The Association suggests that this study provides evidence of bimodality emerging between corporate optometry and independent optometrists under which "corporate optometry" undertakes shorter consultations exposing consumers to risk.

However upon examining the article it is apparent that although Professor Gunn identifies a "bimodality" within the profession with two distinct groups undertaking short and long consultations respectively, he does not draw a distinction between "corporate optometrists" and "independent optometrists" as is suggested by the Association. Professor Gunn only makes one passing reference to the possible cause, namely, "commercial influences".

Evidence from NSW

Under the current law in NSW, optical dispensers can enter into arrangements to have an optometrist conduct their practice from the dispensing premises. The Zifcak Report in Victoria noted that under such arrangements the potential exists for the dispensing company to influence the conduct of the practice by the optometrist. However, only one case has been presented to the Department where it is suggested that this has occurred in NSW.

Conclusions on risks of harm from non-optometrists owning optometric practices

It is the Department's view there is limited evidence to support the claim that non-optometrists may improperly seek to influence the conduct of optometric practices. On balance, the Department is of the view that there are clearly some risks although these are of low level significance. However, while there are risks to consumers, it is apparent that these risks are not isolated to non-optometrist owned practices and have also presented in optometrist owned practices.

It is therefore extremely difficult to justify restrictions that target non-optometrist owned practices such as the current ownership restrictions when the problem appears to be the practising optometrist allowing his/her professional obligations to be over-ridden by commercial considerations.

6.5.2 Impact on increased competition on rural communities

It has been suggested that small independent optometric practices in rural towns will be forced to close if ownership restrictions are removed. The Optometrists Association has sought to draw analogies between the banking industry where services are being withdrawn in rural communities and the optometric profession. In summary, it is suggested that large dispensing chains will purchase independent practices in smaller towns and then rationalise services to major regional centres. Alternatively, dispensing companies will engage in predatory conduct (which the Commonwealth Trade Practices Act 1974 is unable to deal with) forcing smaller operators in rural towns out of business. Rural communities, particularly older and elderly patients, will then have reduced access to optometric services and be forced to travel to major regional centres for eye care services.

The impact of deregulation on any community, particularly rural communities is a significant consideration for the Government. Considerations of access and equity are specifically recognised

under the terms of the Competition Principles Agreement.

However, it is the Department's view that there is little evidence to suggest that this will occur in the optometric market. As was noted above, optical dispensing companies can already conduct co-located facilities with an optometrist. A number of examples have been cited where a large dispenser has purchased the dispensing arm of a business from an optometrist, and the optometrist has continued to operate a consultation only practice from the same premises. However, no evidence has been presented to suggest that this has resulted in the withdrawal of services or that large dispensing firms have engaged in anti-competitive predatory conduct.

The other argument advanced is that the current Act enhances competition by ensuring a number of small independent operators. If large chains are able to purchase a number of practices, then these will no longer be individual competitors and this will reduce competition. While this may be the case, the argument fails to consider the fact that smaller practices may be unable to compete effectively because they cannot achieve economies of scale. It is therefore questionable whether the restrictions facilitate competition as suggested by the Association.

6.5.3 Evidence concerning the costs of the current restrictions

Again evidence concerning the costs of the current restrictions is limited. While the material from the United States suggests there is the potential for significant savings in both consultation fees and the cost of glasses, it is difficult to draw conclusions from this in the NSW market because of the existence of Medicare. There is however sufficient material to suggest that ownership restrictions do have some impact in terms of the price of goods and on the quality of services provided although the significance is difficult to determine.

6.5.4 Achieving the objectives of the legislation

On balance, the Department supports the conclusion reached by ACIL that the benefits of the ownership restrictions would be outweighed by the costs of restricting ownership of practices. While there is some evidence that commercial pressures may over-ride professional obligations resulting in injury to patients, there is little evidence to suggest that the ownership restrictions are effective in preventing this harm from arising, particularly given these problems are also manifest in optometrist-owned practices.

This problem is partially addressed in other recommendations made in this report concerning the disclosure of pecuniary interests and the introduction of mandatory release of prescription requirements. In combination with the complaints and disciplinary system, these measures will ensure that commercial pressures do not over-ride professional obligations.

However, a significant issue remains. While registered optometrists who employ other optometrists can be subject to disciplinary action for improperly influencing professional conduct, non-optometrist owners would not be subject to any sanctions if they engaged in similar conduct. While responsibility for professional standards should ordinarily rest with the practising optometrist, clearly this situation would give “non-optometrist owners” an unfair advantage over “optometrist employers”. Given there is some evidence to support claims of risks to patients, regulatory action is considered appropriate by

the Department.

The Department has identified an alternative to ownership restrictions that will limit the impact on competition. The New Zealand *Dental Act 1988* creates an offence of directing an employee to practise dentistry in a manner that is detrimental to the welfare of the patient. A penalty of $5 000 is imposed for breaching this section. This approach is clearly directed at ensuring that patient care is not jeopardised by such actions.

It is the Department's view that this provides a useful mechanism to sanction inappropriate conduct by employers of optometrists. While this provision would provide a useful mechanism to regulate the conduct of non-optometrist employers, the Department is concerned that:

- the offence is relatively broad and may be difficult to prosecute;
- the penalties may be inadequate to deter inappropriate conduct; and
- there is an issue of fairness involved in that a registered optometrist could be subject to disciplinary action and lose their right to practise while a non-optometrist employer would simply incur a monetary penalty.

The Department therefore proposes the following measures:

- A statutory offence will be created of:

  (i) directing a registered optometrist to provide a service of a kind that is excessive, unnecessary or not reasonably required for that person's well-being; or
  (ii) directing or influencing a registered optometrist such that they engage in conduct that would constitute unsatisfactory professional conduct or professional misconduct.[66]

- If a corporation commits an offence, every director of the corporation or person who is concerned in the management of an optometric business is to be taken to have committed the same offence. A defence would be provided where they could establish they did not know of the offence and they exercised due diligence to prevent the contravention.

- The Regulations will be able to deem certain matters to constitute prima facie evidence of a breach of the statutory offence under (i). Matters that might be considered for inclusion in the Regulation might include setting maximum consultation times.

- Penalties will be set at an appropriate level to discourage such action from occurring, (eg 250 penalty units for a first offence and 500 penalty units for subsequent offences).

- As a further measure to protect the public, the Director-General of the Department of Health will have a discretion to suspend or disqualify a company or a person who is a proprietor, trustee, beneficiary, director, major shareholder or is otherwise involved in carrying on the business of providing consulting optometric services from carrying on such a business if a breach of the statutory offence has occurred and the Director-General is satisfied that the person or company is

66 For definitions of "unsatisfactory professional conduct" and "professional misconduct" see section Chapter 10.

no longer fit and proper to carry on or control the business of providing optometric services. Provision would be made to ensure that the objectives of the legislation are not thwarted by the adoption of business structures or through business restructuring designed to circumvent the exclusion provision. The Director-General would also have the discretion to limit the suspension to specified outlets.

- To ensure that patients of an optometrist who leaves employment at a practice can continue their care with the same optometrist at another practice, the optometrist will be entitled to a copy of that patient's record with the written consent of the patient concerned.

It is the Department's view that these measures will eliminate the potential risks that arise where professional obligations are overridden by commercial considerations. As no entry requirements are set for non-optometrists who wish to provide services, the impact on competition is marginal. The benefits that would flow from removing the restrictions on ownership, including improved quality of services and cheaper eye wear, could be delivered to patients without any increased risk of injury.

Recommendation 8 – Ownership of Optometric Practices

It is recommended that the prohibition on the conduct of the business of the practice of optometry by firms, companies or other unregistered persons be repealed.

Recommendation 9 – Offence of Improperly Influencing the Practice of Optometry

(a) It is recommended that legislation regulating the optometry profession prohibit a person or company from:

(i) directing a registered optometrist to provide a service of a kind that is excessive, unnecessary or not reasonably required for that person's well-being; or
(ii) directing or influencing a registered optometrist such that they engage in conduct that would constitute unsatisfactory professional conduct or professional misconduct.

(b) It is recommended that the legislation be amended to include a regulation making power to enable certain matters to be prima facie evidence of a breach of the prohibition contained in (a)(i).

(c) It is recommended that action under (a)(ii) against a person or company or other business will only be allowed to proceed where the practitioner concerned has been found guilty of professional misconduct or unsatisfactory professional conduct during disciplinary proceedings.

(d) It is recommended that the legislation provide that where a company is convicted of an offence under 9(a), every director or person concerned with the management of the company is also guilty of an offence unless they had no knowledge of the offence and they exercised due diligence to prevent the contravention.

Recommendation 10 – Disqualification of Non-Optometric Service Providers

(a) It is recommended that the legislation provide that the Director-General may suspend or disqualify a company or a person who is a proprietor, trustee, beneficiary, director, major shareholder or is otherwise involved in carrying on the business of providing consulting optometric services from carrying on, or being involved in carrying on the business of providing optometric services (either generally or at specified premises) where:

(i) conviction for an offence contained in recommendation 9(a) has occurred; and
(ii) the Director-General is satisfied that the person or company is no longer fit and proper to carry on, or be involved in the carrying on, the business of providing optometric services.

(b) It is recommended that the legislation make provision to prevent the objectives of the suspension provisions from being thwarted by the adoption of business structures or through business restructuring designed to circumvent the operation of the exclusion provisions.

Recommendation 11 – Availability of Records

It is recommended that registered optometrists be permitted to obtain a copy of a patient's record from a previous employer with the consent in writing of the patient.

7. OTHER CONSUMER ISSUES

7.1 Mandatory Release of Prescriptions

The Issues Paper referred to the issue of whether optometrists should be required to provide a copy of the prescription for contact lenses and glasses that they have prepared to consumers following completion of the consultation. It was noted that such a requirement could be in the public interest as consumers would then be able to decide whether to purchase their optical appliance from the optometrist who performed the examination. If they did not decide to do this, then they could elect to purchase the appliance from another optometrist or optical dispenser. Further, this would avoid the situation where consumers are required to return to an optometrist for a full consultation should they loose their glasses, or require replacement contact lenses.

The matter was considered by the Clinical Issues Working Party which recommended that a requirement be included in the Act to require the mandatory release of prescriptions for contact lenses and glasses (with some exceptions related to contact lenses). However, the Department suggested in the Issues Paper that this may no longer be necessary as optometrists who bill Medicare are required to enter into agreement whereby they agree to release prescriptions (see section 2.8). Instead it was recommended that a regulation making power be included in the Act to enable the matter to be dealt with by Regulation.

MBF Ltd commented as follows:

> *"Preventing consumers from obtaining these prescriptions would strongly disadvantage them. It would strongly diminish their power as the decision maker in the process of choosing the most appropriate means of obtaining optical appliances".*[67]

Although not directly commenting on possible mandatory release provisions, OPSM noted the following:

> "*In most cases, the traditional optometrist's consulting rooms is a closed shop, in that the optometrist tests the eyes and then dispenses the prescription. It is arguable whether the average patient feels they have the right to ask their optometrist for their prescription so they can shop around for the best price for their spectacle frames or contact lenses."*[68]

The Australasian Dispensing Opticians Association notes the following:

> "*With respect to the release of prescriptions, ADOA recommends the release of all prescriptions for optical appliances (spectacles and contact lenses). The comment made in Appendix 1 by the Working Party 4.4 is misleading. That is, the release of contact lens prescriptions through Medicare is a very low proportion of contact lens prescriptions."*

As was noted in section 2.8, most initial examinations by optometrists are bulk-billed to Medicare. However, the Department has since confirmed that Medicare will only pay benefits in respect of the

---

67 Op cit at page 4.
68 Op cit at page 6

fitting of contact lenses where there is a significant change in vision for the patient. Accordingly most patients seeking contact lens prescriptions pay a fee to cover the "fitting process" and the optometrist would not be bound to release a prescription for the contact lenses. Although in practice most practitioners would continue to provide a prescription (whether billed under Medicare or not), there would be no sanction available in a non-Medicare case where a practitioner refused to provide a prescription.

The Department is of the view that a mandatory release requirement for glasses and contact lenses would be of substantial benefit for consumers and would facilitate competition between optometrists and other suppliers of appliances. Further, it should not be left to the consumer to request that prescription. It should be a fundamental professional obligation of all practising optometrists that they release the prescription automatically. It should be recognised that such provisions will impose costs on practitioners in terms of time and resources, but these are likely to be marginal when compared with the competitive benefits that will flow from the requirement.

It is the Department's preferred position for this issue to be dealt with by way of Regulation or through a code of professional conduct. Further consideration will need to be given to the issues of exemptions for certain types of contact lenses and the stage during the fitting process at which the prescription can be released.

Recommendation 12 – Release of Prescriptions

It is recommended that the Act include a provision (either by way of Regulation or through a code of professional conduct) to require the automatic release of prescriptions for optical appliances (including contact lenses) by optometrists.

7.2 Advertising by Registered Optometrists

Advertising by registered optometrists is currently regulated by Clause 20 of the Optometrists Regulation 1995. The existing provisions reflect the misleading and deceptive conduct provisions of the Fair Trading Act (NSW) and the Trade Practices Act (Cth). In addition, the regulation provides advertising must not:

> *(b) Create an unjustified expectation of beneficial treatment; or*
> *(c) Promote the unnecessary or inappropriate use of the services of a registered optometrist or an unregistered person; or*
> *(d) Claim prominence for a registered optometrist or an unregistered person in the practice of optometry; or*
> *(e) Compare the practice of a registered optometrist or an unregistered person with that of any other registered optometrist or an unregistered person.*

The Issues Paper sought comments on whether there is a need for regulatory controls on advertising by registered optometrists in legislation, particularly having regard to the existence of prohibitions on misleading and deceptive conduct under the Trade Practices Act 1974 (Cth) or the NSW Fair Trading Act 1982.

The Optometrists Association of Australia (OAA) argues in its submission the following:

"Clause [20(1)](a) embodies the general principles of the Fair Trading Act and the Trade Practices Act. Clauses (b) to (e) embellish these general business conduct Acts so as to make them specific to the practice of health care and more particularly optometry" [69]

The Board of Optometrical Registration considers it is appropriate to mirror the restrictions in trade practices legislation, noting there are practical difficulties in ensuring compliance with such legislation. The Royal Australian College of Ophthalmologists makes a similar point. The Board also makes the important point that a regulation making power over advertising can be used to ensure that certain information is provided to consumers, for example, the name of the optometrist responsible for the conduct of a practice.

Medical Benefits Fund Ltd emphasise that the regulation making power needs to be maintained to protect the rights of consumers.

The Australian Dispensing Opticians Association, however, argues that all restrictions on advertising should be removed to increase competition. The Nurses Association makes a similar point.

On balance the Department supports the retention of a regulation making power over advertising. While highly prescriptive advertising standards have in the past limited the flow of information to consumers, this is no longer the case. In a market for services where there is clearly a disparity of information between professional and patient as established in Chapter 3, the potential for misleading conduct to have an impact on patients is clear.

Paragraphs (a) through to (c) are comparable to existing advertising restrictions in other generic legislation and have public interest goals of protecting consumers from harm and minimising the potential for over-servicing. While the 'public interest' rationale' of (d) and (e) is less clear, an opportunity to review these standards will arise when regulations under the new legislation are developed.

It should be emphasised that those seeking to argue for the retention of these standards will need to establish that the are substantial public benefits that outweigh the costs of restricting competition. Further the review of these provisions will need to be conducted in accordance with the requirements of the Subordinate Legislation Act 1989.

The strongest argument against regulatory controls on advertising, that is the existing regulations duplicates generic trade practices of fair trading legislation, has superficial merit. However, this argument ignores the fact that the effective regulation of advertising under generic legislation will depend upon the responsible regulatory body, the ACCC of the Department of Fair Trading, taking appropriate enforcement action. The ACCC has recently advised the OAA (NSW) that it is necessarily selective in its enforcement action because it cannot pursue every breach of legislation. The retention of regulatory controls under optometric legislation will ensure that advertising can be acted upon swiftly, without relying on the resources of other enforcement agencies.
It should also be recognised that a regulation making power over advertising can also be used to require certain information to be disclosed. Full consideration will be given to this issue during the

69 Op cit at page 46.

development of Regulations to determine whether competition can be enhanced by requiring certain information to be disclosed.

Recommendation 13 - Advertising

It is recommended that the Act include a provision to enable standards to be set (either by way of Regulation or through a code of professional conduct) for advertising by optometrists (and others entitled to provide optometric services).

8. REGISTRATION CRITERIA FOR OPTOMETRISTS

8.1 Introduction

Section 19 of the Optometrists Act 1930 requires an applicant for registration as an optometrist to be of good character, twenty-one years of age or above and to pay the prescribed fee. The applicant must also hold one of the prescribed qualifications, which are set out earlier in Chapter 2.

Registration requirements are designed to achieve the objectives of the Act by ensuring that those practitioners that become registered will not cause harm to patients, or otherwise jeopardise the public interest. However, if entry level requirements are set unnecessarily high, this may restrict the number of people able to seek registration as optometrists, with a resultant impact on competition. In some cases, registration requirements may not have any connection with securing the objectives of the Act, protection of the public from harm.

The Department is therefore required to assess the current criteria in accordance with the Competition Principles Agreement. In addition, more recent health professional registration legislation have introduced a variety of new registration criteria including physical and mental capacity and proficiency in English. The Issues Paper sought submissions as to whether current registration requirements are appropriate and whether new requirements are necessary or appropriate.

8.2 Good character

The Issues Paper noted that the rationale for a requirement for "good character" is that it ensures that disreputable people are precluded from practising. There may be issues relating to prior sexual misconduct or fraudulent activity that need to be addressed when the practitioner seeks registration. However, it has been argued that the requirement for good character is open to subjective interpretation and can be used to unnecessarily restrict entry to the profession.

Submissions to the review strongly supported a requirement that applicants demonstrate good character, with some arguing that such a requirement only has a marginal impact on competition. The Health Care Complaints Commission sums up the general position:

> *"In all the health professions, only a small number of members are denied entry into the profession on the basis of lack of good character. The cases where lack of good character has been established show that only where there is a serious issue about the person's fitness to remain in the profession will this type of finding be made…*
>
> *"In addition the public have a right to expect that if a professional person's past conduct has demonstrated a fundamental character flaw, that person will not be entitled to continue in practice with the privileges, benefits and responsibilities that entails. Lack of good character is inconsistent with the position of trust that a health professional occupies in our society."*[70]

Only two submissions suggested that the requirement may be overly paternalistic and could be removed.

[70] Submission from the Health Care Complaints Commission dated 14 August 1998 at pages 2-3

Health professionals hold an important position of trust with their patients. A requirement for good character is essential to ensure that consumers are protected from harm in accordance with the Act's objectives. While submissions highlighted numerous examples of where it would be appropriate to refuse registration, for example where a practitioner has engaged in sexual misconduct or fraudulent behaviour, no submissions provided evidence that the requirement is currently used inappropriately.

The issue of whether the requirement should be more narrowly defined to relate directly to 'fitness to practise' has been considered. Across all health professional legislation, substantial case law has developed to ensure that the requirement for good character is only used to refuse registration where it affects a person's fitness to practise. Any attempt to legislatively recognise a perceived semantic difference between the two terms "good character" and "fitness to practise" could result in different (and possibly inappropriate) interpretations being adopted, thus undermining the objectives of the legislation.

8.3 Applicants Must be Twenty-One Years of Age or Above

The Issues Paper noted that an age limit serves to create another barrier to entry, and is in effect rendered inoperative by the Mutual Recognition Act. In addition, most practitioners would be 21 by the time they have completed the required training. Submissions overwhelmingly supported removal of this requirement.

Recommendation 14 – Character

It is recommended that the requirement that applicants for initial registration demonstrate that they are of good character be retained in the new Act.

8.4 Assessment of Competence at Initial Registration - Qualifications.

8.4.1 Introduction

The current Act sets out certain specific qualifications that are recognised for registration. These are in effect all tertiary optometry qualifications offered in Australia and New Zealand. Applicants for registration who do not possess a recognised qualification, principally those from overseas other than New Zealand, may undertake such further optometrical training as the Board requires and demonstrate their competence to practise optometry by undertaking an examination arranged by the Board.

The Issues Paper sought submissions to determine whether the methods of assessing competence for registration are transparent and free from commercial considerations and pressures that may inappropriately restrict entry to the profession. The Issues Paper also canvassed the appropriateness of recognising the proposed national body, the Optometry Council, which has been established to conduct examinations of applicants with overseas training and qualifications and assess overseas qualifications. Another option canvassed to ensure transparency is publishing of accreditation guidelines by the Board with a process, including appeal rights, to allow educational institutions to apply to have courses accredited.

8.4.2 Submissions

Few submissions provided specific comments on this issue other than to suggest that registration requirements are necessary to protect consumers from harm.

> *"Appropriate mechanisms should continue to exist to ensure that optometrists meet, certain established technical standards before they may be registered to practise."*[71]

The Board of Optometrical Registration in its submission supported the current system with some changes:

> *"The Board considers that the assertion in the issues paper a more transparent method of recognising qualifications would be to have a list of prescribed qualifications in the regulation is an expression of faith, rather than substance. In the Board's experience this would be no more transparent than the current system and would serve merely to delay the Board in responding to potential educational changes. The Board has developed its position with respect to these matters over seven years and the transparency and equity of its procedures are second to none."*[72]

The Board also noted the following:

> *"Under the current arrangements examinations are administered by the Board and the Optometry Council. Both examinations are based on agreed competency standards. The Board considers that it would be equitable and appropriate if the Act introduced provision for the Board to require all applicants for registration to satisfy the Board of their competency."*

The Optometrists Association of Australia (NSW Branch) argued in its submission that the newly established Optometry Council should be the only body responsible for examining and assessing overseas applicants:

> *"The advent of mutual recognition made it apparent that uniform system of assessment for overseas graduates was necessary and so in 1996 the Council of Optometric Registration Authorities, in conjunction with the Optometrists Association Australia, established the Optometry Council.*
>
> *The primary objective of The Optometry Council is simple - to provide a single point of assessment for all persons who are not Australian or New Zealand optometry graduates seeking registration in any Australian State or NZ.*
>
> *The new Optometrists Act should recognise The Optometry Council as the sole examiner and/or assessor of non-Australian/New Zealand graduates wishing to practise optometry in Australia."*[73]

While the Board supports the establishment of a national body to provide advice to registration boards

[71] Submission from the Guardianship Tribunal dated 14 July 1998
[72] Submission from the Board of Optometrical Registration dated 12 August 1998 at page 6.
[73] Submission from the Optometrists Association of Australia (NSW Branch) dated 10 August 1998 at page 47.

about standards of education, and competency of applicants for registration who hold non-prescribed qualifications, it is opposed to the express recognition of the Optometry Council in legislation.

> *"The determination of appropriate standards for registration is exclusively a matter for registration Boards, rather than a private company limited by guarantee. It would be contrary to the whole thrust of an Optometrists Act to abrogate the Board's power to control who is registered. The Board's primary consideration at all times is protection of the public interest, whereas the company's primary consideration at all times is the protection of the interest of those controlling the company. In contrast to the company, members of the Board are subject to dismissal by the Governor. Decisions by the Board are subject to statutory judicial review on appeal. The appeal mechanisms against decisions of the company are limited. The Board considers that such recognition should inevitably lead to greater concerns about transparency and fairness than may be the case under the current arrangements."*[74]

OPSM Ltd argued that the current arrangements for the recognition of courses need to be made more transparent.

> *"While recognising that urban NSW is well served by optometry, OPSM supports changes to the Act that provide for a more transparent method of recognising qualifications that are not listed in the Act.*
>
> *Currently, the British qualifications for optometry cannot be registered in Australia or NSW and although the US qualification is equal to that of Australia it also cannot be registered, even though it is a post-graduate qualification.*
>
> *OPSM is in favour of abolishing these restrictions and suggests that a list of certain qualifications and courses deemed to meet high standards set for NSW practitioners should be provided by the individual institutions for approval by the appropriate body. Persons with these qualifications would then automatically meet the competency standards.*
>
> *Such a system would be easier to manage and be far more transparent than the present system under which the Board can recognise qualifications not listed in the Act and it is also preferable to a system under which the proposed Optometry Council would conduct examinations... There would be a cost saving to the Government when examinations are abolished."*[75]

8.4.3 Are current training requirements unnecessarily restricting entry to the profession?

Table 1 shows the number of new applicants who were registered in 1997/1998 under the relevant criteria in the Act.

---

[74] Submission from the Board of Optometrical Registration dated 12 August 1998 at page 6.

[75] Submission from OPSM Ltd dated 14 August 1998 at page 11.

Section	Criteria	Number
19(1)(a)	Holder of a degree of Bachelor of Science (Optometrical Science) or Bachelor of Optometry granted by the University of NSW	43
19(1)(c)	Holder of a Recognised Certificate - University of Auckland, University of Melbourne or Queensland Institute of Technology	4
19(1)(d)	Possess qualifications and undertakes further study or passes an examination to satisfaction of the Board.	1
Mutual Recognition Act	Registered in another State, Territory or New Zealand	38
Total Number of New Registrants for 1997/1998		**86**
Total Number of Registrants as at 30 June 1998		**1260**

All graduates from Australia and New Zealand appear to gain registration under the Mutual Recognition Act. While the overall number is not high, this is likely to be a result of the limited number of training opportunities on offer in Australia.

Only one overseas graduate appears to have gained registration through completion of an examination. The examination operates on a cost recovery basis with applicants charged $875. The Optometry Council charges considerably more. The Department understands that the high cost of the examinations arises from the practical component of the courses. While no evidence has been presented that the current examination is overly onerous or that the costs discourage applicants from sitting the examination, the potential exists for this requirement to restrict entry to the profession.

8.4.4 Demonstrated professional competence

The Board has argued that a requirement should be introduced so that all applicants should be required to demonstrate to the Board their competency. Although this approach would result in consistency and fairness for all applicants, such an approach would result in substantial costs for the applicants or the Board (and possibly the profession given the cost of the Board is covered by registration fees). It is difficult to see how the imposition of an additional barrier to registration such as an examination can be justified in circumstances where as assessment has been made, either at the time of prescribing courses through legislation or by the Board in recognising certain courses, that graduates of certain courses are competent. It is the Department's view that competency should principally be established by applicants through the completion of recognised qualifications.

However, the Board should retain a right to refuse registration where there is a lack of skill or competence as set out in 8.5.

8.4.5 Recognition of courses

The Act specifically recognises courses from the University of NSW. For graduates of other courses, that course must be "recognised by the Board as furnishing sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of optometry in NSW". While the Department accepts the Board's comments that decisions under this section are subject to judicial review and that the process for recognition of courses is transparent and fair, the current Act is somewhat vague in relation to the Board's ability to receive applications from training institutions and in relation to appeal rights. Further, with the development of competency standards for the profession, clearer criteria are available against which courses can be assessed.

It is the Department's view that legislation regulating the optometry profession should provide a clear and transparent avenue through which courses can be accredited. It is therefore proposed that the Act be amended so that the Board can receive applications from educational institutions for accreditation with a right of appeal (on the merits and not just questions of law as is currently the case) to the Administrative Decisions Tribunal. Courses will be assessed against criteria prescribed by regulation, such as competency standards. Decisions on the recognition of courses should be reviewable by the Board and appropriate fees should be prescribed by Regulation for the consideration of applications.

The current situation whereby the course offered by the University of NSW is recognised in the Act itself will be altered.

8.4.6 The Optometry Council (TOC)

As noted by the OAA, the advent of mutual recognition legislation has highlighted the need for a national accreditation body to assess overseas qualifications and conduct examinations where appropriate. In establishing a national body economies of scale are achieved that are not available to state based bodies. This could allow cheaper examinations to be offered (although it is noted that the TOC examination is currently more expensive than that offered in NSW) and allow more frequent, and better quality and consistent assessment of courses.

For these reasons, the Department supports establishment of a national examination and assessment body. Legislation regulating the optometry profession should not prevent the NSW Board from adopting the accreditation or examination processes of a third party where it is satisfied that those processes are adequate. While the Board's concerns regarding the abrogation of its responsibilities under the Act have been noted, it is the Department's view that these responsibilities would be adequately discharged if it assesses and accepts the accreditation or examination processes of the third party.

However, the OAA view that TOC should obtain a statutory monopoly on the assessment of overseas qualifications and examination of overseas applicants is inappropriate. As the Board rightly points out, as currently established there is no process for ensuring that its decisions are subject to appropriate review mechanisms. Further, as currently constituted professional associations, rather

than registration bodies have a high degree of influence through membership of the body. While it is not suggested that TOC is or has operated in a protectionist manner, the potential exists for this to occur and would be enhanced if a legislative monopoly is granted to such a body.

8.4.7 Overseas applicants

The cost of completing examinations, whether through the Board or TOC is of some concern. Such a requirement can create a barrier to entry and could discourage practitioners from overseas from seeking registration. However, it needs to be recognised that practically the Board is not in a position to assess and monitor all overseas qualifications. Where a course has not been 'recognised' by the Board, the option of completing an examination will remain. Nonetheless, the process outlined above for the recognition of courses could overcome some problems for some overseas graduates where the appropriate educational institution seeks accreditation under the Act.

Recommendation 15 - Assessment of Competence at the Time of Registration

It is recommended that the Act provide that an applicant will be entitled to registration where he/she has successfully completed:

(i) a qualification prescribed by the Regulations; or
(ii) a qualification that has been assessed by the Board as meeting the criteria prescribed by the Regulations; or
(iii) a qualification that has been approved by the Board, on the recommendation of another accreditation body; or
(iv) an examination arranged or approved by the Board.

Recommendation 16 – Accreditation of Courses

It is recommended that the Act enable educational or training institutions to apply to the Board to have qualifications assessed or approved in accordance with (ii) and (iii) as meeting the criteria prescribed by Regulation, with a right of appeal on the merits to the Administrative Decisions Tribunal.

8.5 Registration - Competence to Practise

8.5.1 Skill

Although it is recognised that competence should be established primarily through satisfying the qualification requirements, there are significant benefits in including a power to refuse registration in over-riding circumstances where there is evidence available to the Board that an applicant does not have sufficient skill to practise in a safe and competent manner. In the absence of such a requirement, the applicant would need to be registered and then a complaint would have to be lodged immediately by the Board. Clearly, this is inefficient and not in the public interest. In light of the minimal impact on entry, (primarily because the Board would only be able to exercise such a power following an inquiry), the Department is of the view that the benefits in terms of improved information for consumers are likely to outweigh any costs.

8.5.2 Recency of practice

It is conceivable that there may be instances where a number of years elapse between a person's graduation and the lodgement of their initial application for registration. The Issues Paper sought submissions on the issue of whether 'recency of practice" requirements should be introduced so that those practitioners who delay applying for registration or who allow their registration to lapse for a number of years can be required to update their skills.

This situation should be distinguished from circumstances where a practitioner maintains registration but does not engage in clinical practice. Ongoing competency of registrants is discussed in chapter 9.

Some submissions questioned whether such a system would be effective in light of mutual recognition.

> *"There is no evidence that a practitioner who has not practised within the arbitrary recency of practice period is not competent, nor does it ensure that practitioners who have practised within that period are competent."*[76]

However, the Board, MBF Ltd and the OAA (NSW) argued that recency of practice requirements should be introduced. The OAA argued that a person's skills will deteriorate in circumstances where they are not practising:

> *"The OAA would argue strongly that an absence of three-to-five years from clinical practice is prima facie evidence of a paucity of contemporary skills and is should be the responsibility of the applicant to demonstrate to the Board that they are still adequately equipped to safely and effectively carry on the practice of clinical optometry.*
>
> *With regard to wording of the provision, we would strongly recommend the adoption of the wording used by the Victorian Registration Board."*

The Victorian Registration Board has introduced guidelines for re-entry to practice under which those that have been absent for 3 to 5 years are to be counselled by a Board appointed instructor. If there has been an absence of over 5 years, applicants should only conduct clinical practice after formal instruction and certification. If no continuing education has been completed the requirements are varied.

Little evidence has been presented to the review demonstrating that there is a significant problem of practitioners re-entering the profession and posing a risk to consumers. Few complaints appear to have been lodged with the Board in this regard. In the majority of cases, professionals that seek to re-enter the market after a period of absence recognise they have a professional responsibility not to provide any treatment or undertake any tasks beyond their competence. The Department is not satisfied that legislative intervention is necessary to minimise any problem, beyond that which is proposed above in relation to lack of skill. A serious lack of skill arising from a lapse in practice

[76] Submission from the NSW Nurses Association dated 11 August 1998 at page 3

could be addressed through the mechanism outlined in paragraph 8.5.1 (in circumstances where registration has lapsed).

8.5.3 Physical and mental capacity

The current Act does not permit the Board to consider the physical and mental capacity of a person when considering an application for registration. The Issues Paper sought submissions on the issue of whether such a requirement should be introduced.

A number of submissions supported introduction of such requirements, including the Board of Optometrical Registration and the OAA (NSW). Only the Australian Dispensing Opticians Association, questioned the need for such a requirement suggesting that such matters could be left to market forces.

It is the Department's view that as with other health professional registration legislation, the Board should have the power to refuse registration or impose conditions on registration where applicants do not have sufficient physical and mental capacity to practise. While it is not considered necessary to have each applicant positively demonstrate this at the time of registration, a provision that enables the Board to refuse registration in appropriate cases is supported. While the risk of injury is not as high as with other health professionals, clearly optometrists are in the position where impaired judgement could result in adverse patient outcomes, particularly in light of the proposed therapeutic role of optometrists recommended above. The benefits of such a provision include giving the Board greater scope to protect the public interest by preventing or restricting the practice of persons who may not have the physical or mental capacity to practise optometry safely.

8.5.4 English language

The Department sought submissions on the issue of whether applicants should be required to have proficiency in English in order to obtain registration.

The Department considers that this requirement should only be included where there is demonstrated evidence of a need for it. The OAA (NSW Branch), the Board of Optometrical Registration, the HCCC, South Eastern Sydney Area Health Service, MBF Ltd and the Council on the Ageing (COTA) supported introduction of such a requirement. COTA provided the strongest argument advanced in any submission for introduction of such a requirement:

> *"Proficiency in English should be a requirement, as reports from consumers substantiate that communication problems are at the root of many complaints and misadventures between practitioners and patients."*[77]

The Optical Dispensers Licensing Board and the Australian Dispensing Opticians Association presented a contrary view suggesting that proficiency in English should be left to be determined by market forces. Indeed the Department noted in the Issues Paper that an argument can be made that, as optometrists are engaged overwhelmingly in private practice and do not as a rule work as part of a

---

[77] Submission from the Council on the Ageing (NSW) dated 27 August 1998 at page 2

team or in emergency situations, English speaking consumers can simply avoid a practitioner who does not have an adequate command of English, conversely practitioners who speak a community language may be preferred by consumers of non-English speaking background.

Nonetheless, the Department has formed the view that an English language requirement is necessary for the following reasons.

- Consumers could be put to unnecessary expense where they seek out a registered practitioner and they find that the practitioner is unable to communicate effectively.

- The proposed therapeutic role of optometrists will mean that it is necessary for all practitioners to be able clearly explain to all patients that come into their practice, the risks of the drugs they are prescribing, the benefits, the likely effect and possible alternatives to the treatment.

- Administration of drugs (both diagnostic and therapeutic) may result in situations where it is necessary in an emergency to contact other health care professionals for assistance.

- A practitioners without a command of the English language would have difficulty in keeping up with developments in the profession.

As with mental and physical capacity, this should simply form grounds for refusal of registration or for imposing conditions on registration rather than having applicants demonstrate proficiency through an examination. However, to ensure that the provision is not used inappropriately to restrict market entry and discriminate unfairly against persons from a non-English speaking background, the Act should provide that the Board in considering an application must adopt the least restrictive strategy possible (such as the imposition of conditions requiring them to undertake further training to improve their communication skills). Further, the Board may only consider refusal of registration where it is satisfied that practice by the applicant will prevent a significant and serious risk to members of the public.

8.6 Refusal of Registration - Disciplinary Action in a Foreign Jurisdiction

The Mutual Recognition Act 1992 places limits on the ability of applicants from NZ and other states and territories to gain registration where they have been subject to disciplinary action in another jurisdiction. Practitioners from jurisdictions (other than Australia of New Zealand) can however seek registration in NSW and prior conduct, including conduct resulting in deregistration, cannot be considered in the registration process.

The Department supports provisions to enable the Board to refuse registration or place conditions on such practitioners where the conduct would provide grounds for disciplinary action under the NSW legislation.

8.7 Criminal Convictions

All health professional registration Acts enacted in NSW since 1989 provide that the Board may refuse to register a person , otherwise entitled to registration, or impose conditions where the person

has been convicted of an offence that in the opinion of the Board renders the person unsuitable for registration. The current Optometrists Act does not give the Board a separately recognised power to refuse registration in such a case and submissions were sought on this issue.

The Department is of the view that there are strong justifications for including specific requirements relating to criminal offences, including circumstances where offences are proved but no conviction has been recorded. Professional registration legislation serves an important protective role and such a provision would enhance that function. The potential risks were recently highlighted by the Report of the Wood Royal Commission, particularly in relation to sex and violence offences.

Obviously safeguards need to be put in place. If the provisions of other health professional registration Acts are utilised, then the Board's ability to refuse registration would be limited to circumstances where the offence renders the person unfit to practise in the public interest. It is considered appropriate to include matters dealt with under s.556A of the Crimes Act 1900 - that is where an offence is found proved and no conviction is recorded - given that some offences, such as sex and violence offences, have been dealt with under this section in light of the different focus of the criminal justice system. For such a system to be effective, applicants should be required to disclose such matters at the time of registration.

Recommendation 17 – Grounds for Refusing Registration or Imposing Conditions

(a) It is recommended that the Act provide that the Board may refuse registration or impose conditions, subject to a right of appeal to the Administrative Decisions Tribunal, where:

(i) a person does not have sufficient competence to practise as an optometrist, including lack of skill, physical or mental capacity (including addiction to drugs or alcohol) or lack of an adequate command of English;

(ii) a person has been convicted of an offence or has had an offence proved against them which renders them unfit in the public interest to practice as an optometrist;

(iii) a person has been the subject of disciplinary action in another jurisdiction (other than a jurisdiction to which mutual recognition applies).

(b) It is recommended that the Act provide that the Board may only refuse registration on the basis of lack of an adequate command of English after it has considered options that are less restrictive and is satisfied that these options will not provide for the protection from the risk of serious injury or harm.

Recommendation 18 – Inquiries into Registration Applications

It is recommended that the legislation provide that the Board may conduct an inquiry into such an application with similar powers to those which apply under the current Medical Practice Act 1992 following notification to the HCCC. The HCCC will be allowed to appear at the inquiry at the discretion of the Board.

8.8 Declarations by Applicants at the Time of Registration

The Board's ability to give appropriate consideration to applications is limited by its ability to obtain information. To assist the Board in obtaining relevant information, the Board supports the introduction of 'declaration' requirements on new applicants for registration. The Report of the Review of the Medical Practice Act has recommended that applicants be required to disclose the following information at the time of registration (with failure to disclose information subject to appropriate penalties):

- Criminal convictions and offences proved but dismissed under s556A of the Crimes Act; and
- Charges for serious sex and violence offences where the allegations relate to conduct that occurred in the course of practice.

The rationale for requiring applicants to disclose criminal offences and matters dealt with under s.556A is that these circumstances may form grounds for refusal of registration as proposed in recommendation 17. It is therefore appropriate that the Board has access to this information.

In respect of charges for serious sex and violence offences, the fundamental principle of registration legislation is the protection of the public. Much attention has in recent years focussed on misconduct of practitioners from a wide-range of disciplines that have engaged in inappropriate behaviour towards their patients, particularly young people. Where a practitioner has been charged with a serious sex or violence offence, it is imperative that the Board is made aware as this could highlight that a practitioner is not of 'good character' and should not be entitled to practise.

Recommendation 19 – Declarations by Applicants for Registration

It is recommended that the Act provide that applicants for initial registration must disclose:

- Criminal convictions and offences proved but dismissed under s.556A of the Crimes Act; and
- Charges for serious sex and violence offences where the allegations relate to conduct that occurred in the course of practice.

8.9 Registration Categories

The current Act provides that the Board may grant full registration or provisional registration only. Provisional registration can be granted to applicants who are entitled to be registered but whose application had not yet been dealt with by the Board, or where an applicant’s qualification has not yet been conferred by the awarding authority.

Submissions were sought on the issue of whether new categories of conditional registration and temporary registration should be created.

Conditional registration

Introduction of a power to enable the Board to impose conditions at the time of registration would give the Board a greater range of options in dealing with applicants for registration. This is consistent with

other health professional registration Acts.

Submissions where sought on the question of whether conditionally registered people should be prevented from holding themselves out as full registrants or should be required to disclose the conditions on their registration. No submissions directly addressed this issue. However, the Department considers it is important that consumers are made aware that registration is subject to conditions. Therefore such practitioners should only be permitted to describe themselves as conditional registrants.

Temporary registration

The power to grant temporary registration would allow the Board to grant registration to appropriate practitioners, normally from overseas, for a set period of time for purposes such as teaching or research.

Student registration

The Board has recommended that the Act provide that students must be registered. In support of its proposal the Board notes that a similar scheme has been established under the Medical Practice Act 1992. Registration of students of medicine has been established primarily to deal with issues of impairment. No evidence has been provided to the current review of significant problems arising from impairment among students of optometry, or of risks to public health and safety presented by students.

Recommendation 20 – Categories of Registration

It is recommended that the Act provide for the following classes of registration:

(i) full registration;
(ii) provisional registration;
(iii) temporary registration for the purposes of carrying out education, research or any other activity which is in the public interest;
(iv) conditional registration for practitioners that have had conditions imposed on their registration either at the time of registration or following disciplinary action.

Recommendation 21 – Conditional Registrants

It is recommended that the Act provide that conditional registrants may only describe themselves as conditionally registered.

9. CONTINUING REGISTRATION

9.1 Introduction

The current Optometrists Act seeks to provide patients with information about the ongoing competence of practitioners. This is currently done through initial registration criteria, the complaints/disciplinary system and the practitioners professional obligations to maintain their skills at an appropriate level. The Issues Paper sought submissions on possible strategies that might be introduced to encourage professionals to take a more active role in maintaining their professional standards. The following matters were identified for consideration:

- Annual competency assessment;
- Mandatory continuing education;
- Provision of information by applicants for renewal of registration;
- Recency of practice.

9.2 Annual Competency Assessment

MBF Ltd and the Council on the Ageing support annual competency testing. The Nurses Association and the Optometrists Association Australia oppose the introduction of a requirement for demonstrated competence at the time of re-registration.

On balance, the Department does not support the introduction of continuing competency assessment at this time on the basis that the complaints system is sufficient to monitor ongoing competence of optometric practitioners having regard to the general scope of their practice. Overall the level of complaints made involving competency of practitioners does not appear to be high. The cost of annual competency assessment cannot therefore be justified.

9.3 Mandatory Continuing Education

The Health Care Complaints Commission, Optometrists Association Australia, the Board of Optometrical Registration, and the Guardianship Tribunal support introduction of mandatory continuing education. None of these organisations provided substantial material to suggest that the costs of such a system would be outweighed by the benefits. Such a requirement, it is said, ensures that practitioners maintain their standards.

OPSM, the Australasian Dispensing Opticians Association and the Optical Dispensers Licensing Board consider that continuing education should be voluntary.

The Issues Paper noted that such a requirement should only be introduced where there is a problem with professionals failing to maintain standards. There is little point in making participation in continuing education mandatory where professional associations and professionals already recognise their professional responsibilities. The OAA advises that it already conducts an extensive continuing education program. Further, OPSM estimates that it spends $2 000 per year per practitioner on continuing education.

On balance, the Department is of the view that mandatory continuing education should not be made a requirement for re-registration. The option of voluntary continuing education has also been considered. Under such a system, the Board (or a committee) would develop non-mandatory guidelines for continuing education, in particular minimum hours. Practitioners that met the minimum number of hours for accreditation could then advertise that they have met the Board's guidelines for continuing education in the previous year. Although the Department is already satisfied that the professional association takes an active role in ensuring members maintain their competence, such a system would ensure that consumers have access to information, particularly for those practitioners that are not members of professional associations.

The issue of notification of continuing education activities at the time of renewal of registration is discussed below.

Recommendation 22 – Continuing Education

It is recommended that the Act provide that the Board may issue non-mandatory guidelines for continuing education.

9.4 Mandatory Disclosure of Information to the Board

The Issues Paper specifically sought comments on notification of damages awards or settlements at renewal of registration, although there are a range of other potential matters that might also be considered including convictions, offences and action in other jurisdictions.

Few submissions directly addressed this issue. However, the Board of Optometrical Registration has argued that applicants for re-registration should be required to notify the following:

- Convictions for offences;
- Current complaints;
- Refusal or suspension or deregistration in other jurisdictions.

The Optical Dispensers Licensing Board supports notification of criminal convictions and offences.

In general, the Department supports a more comprehensive process for renewing registration to enable the Board to adequately assess whether a registered practitioner continues to be competent to practise and of good character. Further, in some cases, it may be necessary for an obligation to be imposed on a practitioner to notify certain information to the Board at times other than registration. In cases where serious deficiencies are identified, the Board can institute disciplinary action. A number of possible areas have been identified for consideration.

9.4.1 Charges and convictions for offences

Notification of convictions at the time of renewal of registration is supported. Such information may be directly relevant to the practitioner's ability to practise. For the reasons set out earlier in this paper, this should also include information regarding matters dealt with under s.556A of the Crimes Act 1990 (that is offence proved but no conviction recorded).

Further, although not raised in the Issues Paper for consideration, the issue of mandatory notification of charges for serious sex and violence offences was considered in the Report of the Review of the Medical Practice Act 1992. A fundamental principle of registration legislation is the protection of the public, and in recent years much attention has focussed on misconduct of practitioners from a wide-range of disciplines who have engaged in inappropriate behaviour towards their patients, particularly young people. Where a practitioner has been charged for a serious sex or violence offence, it is important that the Board is made aware as soon as practical so that consideration can be given to taking action to protect the public. Charges for serious sex and violence offences could highlight a practitioner's unfitness to practise and even though they have not been tried, could justify conditions being imposed on a practitioner's registration to ensure that the public is protected. The Department therefore supports mandatory notification of such matters at the time of renewal.

9.4.2 Continuing education

The Report of the Review of the Medical Practice Act 1992 has recommended that practitioners be required to disclose at the time of re-registration the continuing education activities they have undertaken in the previous twelve months. Introduction of such a requirement would prompt practitioners to turn their minds to the amount of continuing education activities that they have undertaken in the previous twelve months. Further this will enable the Board to consider the types of practitioners who are receiving further education, its standard and relevance to practice and the types of organisations which are delivering continuing education.

9.4.3 Complaints

It is difficult to determine what benefit a requirement that practitioners disclose current complaints would have as complaints are already made to the Board or the HCCC. While other 'complaints' could be notified, this would essentially be left to the discretion of the practitioner and would be difficult to enforce. A strong argument can also be made that such matters can be brought to the attention of the Board by the patient if they wish to pursue this course of action. Many patients may not wish to take such action preferring to resolve the matter directly with the practitioner. Action on behalf of the Board to inform consumers about their rights to make a complaint would possibly be more effective.

9.4.4 Complaints/disciplinary action in other jurisdictions

It is the Department's view that existing arrangements under Mutual Recognition Act are adequate for ensuring conduct in other jurisdictions is brought to the attention to the Board.

9.4.5 Serious illness related to physical and mental capacity

Such matters may be relevant to determining whether a practitioner has sufficient capacity to practise.

Recommendation 23 – Renewal of Registration

It is recommended that Act provide that applicants for renewal of registration be required to make declarations on:

- Criminal convictions (recorded and unrecorded);
- Charges for serious sex or violence offences where the allegations relate to conduct occurring in the course of practice;
- Significant illness for the purposes of identifying whether there may be issues of physical or mental capacity (including addiction);
- Continuing education activities.

9.5 Criminal Convictions

The criminal justice system can provide information relevant to whether disciplinary action should be initiated against a practitioner. The Department has been considering all health professional registration Acts to ensure that they continue to reflect the high standards expected by the community by adequately addressing questions of character and criminal conviction. The Department has identified a number of strategies that would be of assistance in this regard.

These strategies would complement the expanded renewal process outlined above. They are as follows.

- Courts are to be required to notify the Board of any practitioners who are convicted of an offence. Currently only the Medical Practice and Physiotherapists Registration Acts contain such provisions. Under the Medical Practice Act, the courts are required to notify the Board if a practitioner is convicted of an offence, unless it is one prescribed by regulation.

- Practitioners are to be under a positive obligation to notify the Board if they are convicted of an offence of a type reportable by the courts. This will provide an additional means for obtaining relevant information in a timely manner and will emphasise to practitioners the potential seriousness with which criminal convictions should be regarded. This requirement would operate in conjunction with the obligation to make a declaration at the time of renewal on such matters.

- Practitioners are to be under an obligation to notify their Board within seven days of charged with a "serious sex or violence offence" where the allegations relate to conduct occurring in the course of practice. A "serious sex or violence offence" would be defined as an offence involving sexual activity, acts of indecency, physical violence or the threat of physical violence that would be punishable by imprisonment for 12 months or more. As above, this requirement would operate in conjunction with the obligation to make a declaration at the time of renewal on such matters.

A criminal charge per se would not constitute the basis for disciplinary action. Rather , the charge and the circumstances surrounding it can be relevant to a practitioner's overall ability to practise and to questions of character. It should be noted that under the Health Services Act employees and visiting practitioners appointed by a public health organisation who have been charged with or

convicted of a serious sex or violence offence are under a positive obligation to report that information to the CEO of the organisation.

Recommendation 24 – Criminal Convictions

It is recommended that the Act provide for the following:

- Courts be required to notify the Board of any practitioners who are convicted of an offence (irrespective of whether it is recorded or not) unless it is an offence of a type that is not required to be notified to the Board;
- Practitioners be required to notify the Board within seven days if they are convicted of an offence which is reportable by the courts; and
- Practitioners be required to notify the Board within seven days if charged with a "serious sex or violence offence" where the allegations relate to conduct occurring in the course of practice.

10. COMPLAINTS AND DISCIPLINARY STRUCTURES

10.1 Introduction

An effective complaints handling and disciplinary structure can be used to monitor and enforce practice and ethical standards in the profession and help to reduce the incidence of consumer dissatisfaction. In short it can enhance competition by improving the information available to consumers. However where disciplinary structures are used to restrain commercial activity, such as advertising, they may have an anti-competitive effect which is of little or no benefit to consumers.

As noted in Chapter 2 the Board can reprimand, caution or remove from the register a practitioner who has been convicted of an offence, or if following an inquiry they have been adjudged to be guilty of misconduct in a professional respect.

The Issues paper noted that the complaints and disciplinary procedures of the current Act are inconsistent with the provisions of other health professional legislation, and a number of administrative problems have been identified by the Board in recent years. The Issues Paper sought submissions on a range of options to update the existing provisions. Submissions were also invited on the costs and benefits of the current arrangements and alternative options in accordance with the Competition Principles Agreement.

10.2 The Need for a Complaints and Disciplinary System

As discussed in Chapters 3 and 4 of this Report patients lack the ability to assess the quality of services they are provided with. The Board and Health Care Complaints Commission receive a number of complaints in relation to registered optometrists. Similarly, the Department of Fair Trading receives complaints about optometrists, many of which are referred to the Board for assessment under the Optometrists Act 1930. This provides some evidence for the need for ongoing monitoring of the professional conduct of optometrists.

Submissions strongly supported retention of a complaints handling and disciplinary system. In the absence of a complaints system:

> *"[If].. serious deficiencies in the competency of an optometrist, unethical conduct of an optometrist or the mental/physical incapacity of an optometrist were identified, it would not be possible to take appropriate disciplinary action to ensure that the public were protected."*[78]

While a professional association could carry out the disciplinary function, the effectiveness of such a system would be undermined by the inability of such organisations to effectively impose disciplinary sanctions. Practitioners could simply resign from the association, but because they remain registered, they could continue to practise possibly exposing consumers to risks. Similarly, reliance on a civil system, such as the Consumer Claims Tribunal, or through the local courts could provide some redress, this:

> *"…could be costly, lengthy and stressful, and would not provide the adequate protection against incompetent, unethical or unfit optometrists afforded through the present health*

---

78 Submission from the Health Care Complaints Commission dated 14 August 1999 at page 2

system complaints mechanisms."[79]

While the Health Care Complaints Commission could continue to receive complaints, its ability to take action is limited in the absence of a disciplinary system. These issues are highlighted by the recent report of the Standing Committee into the Health Care Complaints Commission on unregistered health professionals.[80]

The need for ongoing monitoring of professional standards will increase if the recommendation above to provide optometrists with access to therapeutics is adopted.

On balance, the Department supports retention of a complaints and disciplinary system. The potential for such a system to restrict competition should however be minimised wherever possible. This is discussed as appropriate in the remainder of this chapter.

10.3 Grounds for Complaints and Disciplinary Action

The current Act does not set out the grounds for making complaints about registered optometrists, although in practice the Board receives complaints on a range of matters. Similarly, the Health Care Complaints Commission receives complaints in accordance with the provisions of that Act.

The Issues Paper sought submissions on what the grounds for complaint should be under the Optometrists Act 1930, and whether these should be consistent with other health professional registration Acts such as the Nurses Act 1991. That Act provides complaints may be received about a practitioner in the following circumstances.

- A practitioner is guilty of unsatisfactory professional conduct (to deal with less serious matters) or professional misconduct (for more serious matters) as defined by the Act.
- A practitioner has been found guilty of an offence in circumstances that renders the practitioner unfit, in the public interest, to practise.
- A practitioner has insufficient physical or mental capacity to practise.
- A practitioner is addicted to drugs or alcohol.
- A practitioner is not of good character

Few submissions specifically commented on the appropriate grounds for complaint, other than to express support for the introduction of the two-tiered statutory definition of misconduct, although a number expressed support for similar principles to those which apply under the Nurses Act 1991.

10.3.1 Statutory definition of unsatisfactory professional conduct and professional misconduct

The Department supports codification of the definition of misconduct. Although the current ground in the Optometrists Act 1930 of "misconduct in a professional respect" provides a basis for disciplinary action , and has been given meaning by the common law, the failure to define this more clearly in the legislation creates considerable uncertainty for practitioners. Further it fails to adequately set out the community's expectations of practitioners in relation to skill, judgement and competence.

---

79 Submission from the Council on the Ageing dated 27 August 1998 at page 1.

80 Joint Committee on the Health Care Complaints Commission *Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints – Final Report* (1998)

By relying on the Courts to give meaning to the phrase "misconduct in a professional respect", the standard of "gross reprobation of ones peers" is applied. This effectively limits the matters that can be the subject of complaint to matters of serious misconduct, and may not offer the public protection from less serious conduct, which nonetheless may expose consumers to harm or otherwise be contrary to the public interest. A two tier definition is necessary to highlight that both serious and less serious matters can be the subject of disciplinary action and will prevent the courts from reading down the provisions to ensure that conduct which does not attract "gross reprobation" can still form grounds for complaint, and if appropriate, disciplinary action.

The content of the definitions of "unsatisfactory professional conduct" and "professional misconduct" is discussed in the section 9.4.

10.3.2 Character, physical and mental capacity, addiction to drugs or alcohol

The Department has considered character, physical and mental capacity, and addiction to drugs or alcohol as grounds for registration and has recommended that the legislation provide the Board may refuse registration where these criteria are not met. The advantages and disadvantages have been considered in this context. As a practitioner's ability to meet these criteria will vary during the course of professional practice, it is recommended that they also form grounds for a complaint to prevent any inconsistency arising.

10.3.3 Criminal conviction

The Board already has a discretionary power to remove a person's name from the Register where they have been found guilty of an offence. This should therefore form grounds for complaint. More recent health professional such as the Nurses Act 1991 and the Chiropractors and Osteopaths Act 1991 provide that this can only form grounds for a complaint (and removal from the Register) where it renders the person unfit in the public interest to practise.

Although it would appear that the Board has a much broader discretion than other disciplinary bodies, in practice the common law would limit the exercise of the Board's discretion consistent with other legislation. This position should be reflected in the legislation to ensure that it is only offences that affect the practitioner's ability to practise in a manner consistent with the public interest which will form grounds for removal.

During the course of the Review of the Medical Practice Act 1992 it has become apparent that instances have arisen where Courts have found that offences have been proven beyond a reasonable doubt, however, no conviction has been recorded under section 556A of the Crimes Act or an equivalent provision. In some cases this has occurred in cases involving sex or violence offences. While the use of s 556A of the Crimes Act 1900 by a Court may be appropriate in criminal proceedings, the primary purpose of registration legislation is the protection of the public. It is the Department's view therefore, that matters dealt with under s 556A should also be reviewed through the complaints and disciplinary system to determine whether the public interest requires that further action be taken.

10.3.4 Establishment of a Complaints Assessment Committee

This Report canvasses below the introduction of an Optometric Care Assessment Committee (OCAC) to assess, conciliate and investigate complaints. This model is based on the Dental Care Assessment Committee established under the Dentists Act 1989. This body would have jurisdiction to conciliate or make recommendations concerning the nature of the treatment provided. If this system is introduced, the grounds of complaint will need to reflect the types of matters that can be brought before the OCAC.

Recommendation 25 – Grounds for Complaints

It is recommended that the Act provide that the Board may receive complaints and take disciplinary action where:

- A practitioner is guilty of unsatisfactory professional conduct (to deal with less serious matters) or professional misconduct (for more serious matters) as defined by the Act.
- A practitioner has been found guilty of an offence (including cases where the offence is found to be proved but no conviction is recorded) in circumstances that render the practitioner unfit, in the public interest, to practise.
- A practitioner has insufficient physical or mental capacity to practise.
- A practitioner is addicted to drugs or alcohol.
- A practitioner is not of good character.

10.4 Content of the Definitions of Unsatisfactory Professional Conduct and Professional Misconduct

Submissions were sought on what the content of the definitions of unsatisfactory professional conduct and professional misconduct should be. In general, other health professional registration Acts define "unsatisfactory profession conduct" as:

- Any conduct which demonstrates a lack of adequate knowledge, skill, judgement of care in the practice of the relevant profession;
- A contravention by the practitioner of the Act or Regulations;
- A failure by a practitioner to comply with conditions on registration, or with an order or determination of the Board (or other relevant disciplinary body);
- A practitioner holding him or herself out as having qualifications in the profession other than those recorded in the register; and
- Any other improper or unethical conduct relating to the practice of the profession.

"Professional misconduct" is defined as "unsatisfactory professional conduct" of a sufficiently serious nature to justify the removal of the practitioner's name from the Register.

Again submissions generally failed to comment on the specific content of the definitions, although many expressed support for a definition consistent with other more recent health professional registration Acts. In addition to those outlined above, the Department has identified through the review of the Medical Practice Act a number of other potential matters which it may be appropriate to include within the definition of misconduct.

10.4.1 Lack of adequate knowledge, skill, judgement or care

It is the Department's view that there are substantial benefits to the community from including such conduct within the definition of unsatisfactory professional conduct. This relates principally to the ability of practitioners to provide services without injuring the public and is consistent with the objectives of the legislation. While such a restriction may have a general impact on competition, particularly where a practitioner is deregistered, such decisions would only be made by an appropriately constituted disciplinary body with adequate non-professional representation and with rights of appeal.

10.4.2 A contravention of the Act or Regulations

Offences under the Act are likely to include procuring registration through fraudulent means, offences against advertising standards as set by regulation and various other matters. As the potential impact of such a requirement on competition has been assessed in recommending the offence, or in developing the regulations, no further consideration is necessary in this context. The Department is of the view that if a matter is considered significant enough to warrant creation of an offence in the Act or regulations, then failure to obey that requirement by a registered person raises a fundamental issue of professional responsibility and should be reviewable in a disciplinary context.

10.4.3 Failure to comply with a condition on registration, or an order or direction of the Board or a disciplinary body

Conditions can only be imposed at the time of registration in specified circumstances (see Chapter 7) or following a disciplinary hearing when a complaint is proved. The circumstances in which orders and direction are made are discussed elsewhere. As with contravention of an Act or Regulations, failure to obey that requirement by a registered person raises a fundamental issue of professional responsibility and should be reviewable in a disciplinary context.

10.4.4 A practitioner holding him or herself out as having qualifications other than those recorded in the Reguister

The Department has recommended in the Report of the Review of the Medical Practice Act 1992 that this be removed from the definition of misconduct. While the Board's power to record such qualifications and titles should be retained, as it provides a source of information for consumers, the prohibition on using qualifications not recorded in the Register should be removed because it limits the information available to consumers, particularly in circumstances where the Board takes an unnecessarily restrictive view of the qualifications that should be recorded.

10.4.5 Any other improper or unethical conduct relating to the practice of the profession

This provision is necessary to ensure adequate protection of the public. Matters commonly considered under this provision in other health professional registration Acts include sexual misconduct, inappropriate relationships with clients, fraud, and over-servicing. In the absence of a general provision such as this, inappropriate professional conduct which was is not specifically referred to (either because it has not been contemplated at the time legislation is passed or for other reasons) may not be able to be dealt with in an appropriate case. It is difficult, however, to define completely all matters that may constitute misconduct.

Use of this provision is limited in that it must relate to the professional's ability to practise. Further decisions are only made by an appropriately constituted disciplinary body with rights of appeal. No evidence has been presented to suggest that such a provision be used to restrain commercial conduct.

10.4.6 Failure to respond to a Board request for information without reasonable excuse

The Report of the Review of the Medical Practice Act 1992 recommended that the definition of unsatisfactory professional conduct be amended to include the above ground. The Report noted that other states have such a ground. Further, the NSW Medical Board had found that a number of complaints were being delayed because of unreasonable delays on the part of practitioners the subject of complaints. To ensure the timely handling of complaints under legislation regulating the optometry profession, introduction of a similar requirement is supported.

10.4.7 Over-servicing

The potential for over-servicing to arise in the optometric profession is significant because of the fusion in many practices of the prescribing of optical appliances and their subsequent dispensing. Some submissions to the review have argued that optometrists in fact obtain 75% of their income from dispensing and that this creates a significant potential for over-servicing.

The optometric profession through the Optometrists Association has highlighted in the debate on restrictions on ownership of the dangers of commercial imperatives over-riding professional responsibilities and has provided material to support this claims. Further, the Association argues that optometrists should refrain from such activity as this would amount to an abuse of the professional relationship.

The reform of ownership restrictions, recommended in Chapter 6, makes it essential that optometrists (whether in private practice or employed by another organisation) are aware of their professional responsibilities to minimise the potential for over-servicing. Inclusion of over-servicing within the definition of unsatisfactory professional conduct, as recommended in the Report of the Review of the Medical Practice Act 1992, is strongly supported by the Department. Breaches of this provision would probably generally proceed following a prosecution by the Health Insurance Commission for breaches of obligations under Medicare.

The need for sanctions against non-optometrists that seek to facilitate over-servicing or otherwise seek to induce an optometrist to breach their professional obligations is addressed elsewhere in this Report.

10.4.8 Failure to disclose a conflict of interest

The Department has recommended in the Report of the Review of the Medical Practice Act that where a medical practitioner refers a patient to another institution or service provider in which the practitioner has a financial interest or from which he or she will receive a benefit, the practitioner be required to disclose that interest or benefit to the patient. The application of this provision to the optometric profession is extremely difficult, because in many cases, the optometrist will own the dispensing business from which optical appliances are prescribed and it will be self-evident to the consumer that the practitioner has such an interest. The benefits of such disclosure in these circumstances may be of limited benefit, particularly in light of the recommendations made above concerning the mandatory release of prescriptions. It may be more appropriate to require

practitioners to advise clients that they can have the prescription filled by another dispenser if they choose.

Notwithstanding this point, there are other instances where practitioners have conflict which should be disclosed, for example, in instances where they refer patients to other practices for other services (for example a medical practice specialising in the correction of vision problems with lasers) in which the optometrist has an interest. Alternatively, a "bounty" may be paid where such a patient is referred.

While this issue requires further consultation, it is recommended that the definition specify that "unsatisfactory professional conduct" includes failure of a registered optometrist to provide information to patients of a type prescribed by Regulation. Further consultation can occur in the development of regulations.

Recommendation 26 – Definition of Misconduct

(i) It is recommended that Act define 'unsatisfactory professional conduct' as:

- Any conduct which demonstrates a lack of adequate knowledge, skill, judgement of care in the practice of optometry;
- A contravention by the practitioner of the Act or Regulations;
- A failure by a practitioner to comply with conditions on registration, or with an order or determination of the Board (or other relevant disciplinary body);
- Conduct which involves:
  (a) providing a service of a kind that is excessive, unnecessary or not reasonably required for the person's well-being; or
  (b) influencing or attempting to influence the conduct of a practitioner in a manner which would constitute professional misconduct or unsatisfactory professional conduct;
- Failure to disclose information of a type prescribed by the Regulation (eg pecuniary interests);
- Failure to respond to a Board request for information without reasonable excuse; and
- Any other improper or unethical conduct relating to the practice of optometry that would render the person unfit in the public interest to practise optometry.

(ii) It is recommended that the Act define “professional misconduct” as unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising optometry or the removal of the practitioner’s name from the Register.

10.5 Codes of Conduct

More recent health professional registration Acts make provision for Boards to develop or make codes of professional conduct. Although compliance with these codes is not mandatory, a serious breach could form the basis of disciplinary action against the professional concerned. However, the Issues Paper noted since such codes can restrict market behaviour and impose compliance costs on members of a profession, it is necessary to determine whether such a provision is consistent with the Competition Principles Agreement.

Alternatives to the model used in other professional registration Acts were also identified for consideration to ensure that codes are not anti-competitive or otherwise contrary to the public interest, and that adequate consultation occurs during development of the code. These include adopting the code by Regulation, Ministerial approval or disallowance by Parliament.

The issue of whether a breach of the code should form grounds for disciplinary action was also raised for consideration.

The Board of Optometrical Registration, the Council on the Ageing, the Health Care Complaints Commission, the NSW Health Funds Association, the Optical Dispensers Licensing Board and the NSW Nurses Association supported the need for a code of conduct. These organisations argued that the code provides a useful statement of the standards and behaviour expected of practitioners and provides protection for consumers.

The Optometrists Association of Australia (NSW Branch) expressed concern at this proposal arguing it is "anathema to the principles on which legal justice is based":

> *"The difficulty with the incorporation of a non-mandatory Code in the Act is that it would at the same time give optometrists only a general form of guidance as to the type and level of conduct expected of them whilst providing the civil courts with a checklist of behaviours with which to berate the profession if a matter is brought before them".*[81]

The Department considers there is a need to establish codes of professional conduct within legislation regulating the optometry profession. In addition to the reasons set out in submissions as outlined above, the following factors are relevant.

- While the need for clear standards can be addressed by the profession itself, through Board policies, or other organisations it can be difficult for professionals to determine an appropriate standard to follow particularly where there are conflicting standards on particular issues.
- Codes developed by professional associations or others may deem certain forms of conduct unethical. This may not be in the public interest. In particular, matters may be deemed unprofessional by an association and have an adverse impact on legitimate commercial conduct. Practitioners may feel obliged to observe such standards even though not legally binding.
- Disciplinary bodies or Courts can use codes as evidence of appropriate standards in determining whether to take action. If developed under legislation, appropriate checks and balances can be put in place to ensure they reflect both community expectations and professional standards.
- Codes can assist in educating consumers as to their expectations.

The potential anti-competitive effect of codes can only be considered once the content of the code is known. It is therefore essential that the processes for developing the code ensures that appropriate consultation occurs and that regard is had to the costs and benefits of specific restrictions, and alternatives.

It is therefore proposed to establish a process in the legislation for developing the code of professional conduct to ensure that the matters it addresses are appropriate and that it does not enshrine anti-competitive practices or sanction conduct that is not in the public interest. It is proposed that the draft code be released for public comment along with an impact assessment report. Further, the code will be required to be approved by the Minister. This will ensure that the code is appropriate and targeted to real public interest issues. The report will be developed in

---

81 Submission from the Optometrists Association Australia (NSW Branch) dated 10 August 1998 at page 53.

accordance with criteria that will be broadly similar to those set down for the preparation of regulatory impact statements under the Subordinate Legislation Act 1989.

The issue remains as to whether a breach of the code should form grounds for a complaint. If the complaint were proved it would then form the basis for the imposition of disciplinary sanctions. The key issue in determining whether disciplinary sanctions should be imposed is whether the conduct complained of constitutes unsatisfactory professional conduct or professional misconduct, and not whether the code has been breached. The Act will however clarify that a breach of the code may be considered as evidence of unsatisfactory professional conduct or professional misconduct in disciplinary hearings.

Recommendation 27 – Codes of Conduct

It is recommended that the:

(a) Minister may approve a code of professional conduct developed by the Board
(b) the Board must release a draft code and impact assessment report for public comment;
(c) the legislation clarify that a breach of the code may be considered as evidence of unsatisfactory professional conduct or professional misconduct.

10.6 Dealing with Complaints

10.6.1 Disciplinary and other bodies

Under the current system, disciplinary sanctions are imposed by the Board after a hearing. The Issues Paper identified a number of problems including: decisions relating to de-registration are not undertaken by a body chaired by a legal practitioner; and the lack of an independent disciplinary body with an appropriate mix of professional, community and legal representatives to deal with serious matters.

The Issues Paper noted that the Medical Practice Act, the Nurses Act and the Chiropractors and Osteopaths Act have adopted a two-tiered Professional Standards Committee/Tribunal structure. This system is outlined below as option 1.

10.6.2 Submissions

While a number of submissions supported the establishment of a PSC/Tribunal structure to deal with complaints, few provided detailed comments on the advantages or disadvantages of this approach. The Optometrists Association Australia strongly supported the introduction of professional standards committees because:

"…it divorces the registration board from having to exercise the triple (but potentially conflicting) roles of prosecutor, jury and judge.

> *"PSCs can significantly reduce the costs, both in time and monetary terms, of hearing complaints against a professional and yet they have the great benefit of introducing the perception and reality of procedural fairness into the system ."*[82]

---

82 Submission from the Optometrists Association Australia (NSW Branch) dated 10 August 1999 at page 51.

No comments on the benefits of Tribunals were provided by the Association. The Health Care Complaints Commission note that the PSC/Tribunal system provides greater flexibility for dealing with complaints and is consistent with other health professional registration Acts. Only the Australian Dispensing Opticians Association argued that the disciplinary function should remain with the Board.

In reviewing submissions and during the course of other health professional legislation reviews, the Department has formulated two options for reforming the disciplinary system.

10.6.3 Option 1 - PSC/Tribunal Structure

Option 1 would involve the establishment of the two-tiered disciplinary system as used under the Medical Practice Act 1992, and the Nurses Act 1991. Professional Standards Committees (PSCs) would deal with less serious complaints of unsatisfactory professional conduct and Tribunals would deal with serious complaints of professional misconduct. The relevant Board no longer has a role in determining whether a practitioner has been guilty of inappropriate conduct.

Two members of the relevant health profession and one lay person who may be legally qualified constitute PSCs. If there is no legally qualified person appointed the PSC may be assisted by a legal practitioner appointed by the Registrar of the Board for that purpose. Proceedings are generally less formal and legal representation is not allowed. Decisions are appealable to the Tribunal and such appeals proceed by way of re-hearing.

Tribunals are chaired by a legal practitioner of sufficient experience and standing. Two professionals and one lay person are also appointed. The Chair has a deciding vote in the event of a tied decision. Because of the seriousness of matters before the Tribunal legal representation is permitted and the Tribunal has power to award costs. Appeals are limited to points of law or severity of order and are generally heard in the District Court.

The procedures established in Part IV (Division 2 and 3) of the Medical Practice Act for decision-making in relation to complaints would be utilised. Under these arrangements, complaints made to the Board are to be referred to the HCCC and vice versa. The HCCC and the Board must consult on the complaint (in accordance with the provisions of the Health Care Complaints Act 1993) to see if agreement can be reached between them. The Board can (following consultation) refer the complaint to a PSC or Tribunal, direct the practitioner to attend for counseling, refer for conciliation to the Health Conciliation Registry, or dismiss the complaint. The HCCC cannot direct that the practitioner attend for counseling. Complaints referred to a PSC or Tribunal must first be referred to the HCCC for investigation.

In accordance with the provisions of the Health Care Complaints Act, the organisation with the more serious view of the complaint prevails. Both the Board and the HCCC are under a duty to refer serious matters (other than matters relating to the practitioner’s physical or mental capacity) to a Tribunal.

This system has the advantage over the current system in that the Tribunal/PSC places a higher degree of emphasis on affording the parties natural justice. It is the Department's view that in situations where a professional's livelihood is at stake because of the threat of deregistration, it is essential that a legal practitioner chair such hearings and that the process remain independent of the Board (which has a role in determining what action to take in relation to a complaint) as far as possible. This system is supported by the Board and the HCCC.

10.6.4 Option 2 - A system based on the Dental Care Assessment Committee

Option 2 is based on the complaints handling and disciplinary model which exists under the *Dentists Act 1989*. The disciplinary structure in the Dentists Act provides, amongst other things, for the Dental Care Assessment Committee (DCAC) to conciliate and investigate complaints about dentists and make recommendations to the Board for their resolution.

The DCAC provides a forum for independent expert assessment of concerns raised by patients as to the standards of dental services provided to them, and to dispute fees charged for those services. The DCAC also provides a means for the Board to receive a more detailed assessment of a complaint before determining how to proceed. In this regard, the Committee can refer a patient for an independent examination and obtain such other evidence, professional reports and advice, as it considers desirable.

The DCAC is made up of three dentists and a consumer representative, and provides the Board with a mechanism through which complaints can be investigated and/or conciliated. The DCAC is able to consider complaints that involve both treatment and fees charged for treatment. Where a complaint concerns fees section 41 of the Dentists Act sets out a list of specific matters that must be considered by the DCAC[83]. Where a matter cannot be resolved by the DCAC with the consent of the parties involved or there are issues which the DCAC considers should be brought to the attention of the Board, the Committee refers the matter back to the Board with a recommendation for action. As well as making recommendations with respect to fees and charges the DCAC can recommend that a practitioner be cautioned or reprimanded, or may make any other recommendation it considers necessary. The Board does not have to accept the DCAC's findings or recommendations and may in appropriate cases refer a matter for a disciplinary hearing notwithstanding the DCAC's successful conciliation of a complaint.

If this model were adapted for use for the optometry profession, the Department proposes that the recommended two tier definition of misconduct be applied through a two tiered Board inquiry/Tribunal structure that incorporates a DCAC type body. If such a structure were adopted then complaints of unsatisfactory professional conduct would be considered by the Board after investigation by the equivalent DCAC body, the HCCC or the Board's own inspector, and complaints of professional misconduct would be considered by the Tribunal. This would ensure that appropriate principles of natural justice are observed for serious matters that might involve deregistration.

If a DCAC type body was to be established within the legislation for the registration of

---

83 Under section 41, the Committee is to have regard to :

- the time occupied in performing and the nature of the dental treatment rendered;
- the distance between the consulting room or residence of the dentist and the place at which the dentist rendered the dental treatment;
- the hours of the day or night at which the dental treatment was rendered;
- the degree of skill, knowledge or experience required or given in rendering the dental treatment;
- whether the dentist rendered the dental treatment in the capacity of specialist, consultant or dentist in ordinary practice;
- what amount, if any, was paid by the dentist to any other person in respect of any dental prosthesis used in the dental treatment;
- any other matter which appears relevant to the Committee.

optometrists the Department envisages that matters requiring a hearing for unsatisfactory professional conduct would be conducted before the Board which is not legalistic or bound by the rules of evidence. Legal representation would not be allowed. This would minimise the current costs associated with current Board hearings.

The Board would be able to make the following orders:

- counsel or reprimand the practitioner;
- order the practitioner to seek medical or psychiatric treatment or counselling;
- order the practitioner to undertake additional training;
- order the practitioner to seek advice on the management of their practice;
- order the practitioner to report on the status of their practice to the Board, or its nominee; and
- impose conditions on the practitioner's practice.

A practitioner who is aggrieved by a decision of the Board would be able to appeal by way of re-hearing to the Tribunal in all cases.

The Tribunal would be able to make all the orders available to the Board as well as suspend or de-register the practitioner.

Notwithstanding the fact that the Tribunal would hear complaints of professional misconduct it will be able to make a finding of unsatisfactory professional conduct.

In situations where the Board considers a complaint that a practitioner does not have sufficient physical or mental capacity to practice, it can recommend suspension or de-registration of the practitioner. In such a case the recommendation of the Committee must be referred to the Chair or a Deputy Chair of the Tribunal who may make an order in the terms recommended by the Committee, or such other order regarding suspension or de-registration, as thought appropriate or impose any other protective order available to the Committee. This exception parallels section 63 of the Medical Practice Act.

10.6.5 Role of the Health Care Complaints Commission

In considering changes to the disciplinary structure it must be remembered that the Health Care Complaints Commission (HCCC) is the independent body created by the Health Care Complaints Act 1993 to receive and investigate complaints about health care providers and institutions. The HCCC must therefore have a role in whatever disciplinary structure is adopted.

If **option 1** were adopted, the role of the Commission would be based on the complaints handling process under the Medical Practice Act 1992. This would overcome the problem with the current Act which is noted in the Issues Paper, that the Board is not obliged to follow the recommendation of the HCCC in determining what action should be taken following investigation of a complaint. The Paper considered that in determining whether to pursue a matter as unsatisfactory professional conduct or professional misconduct through a hearing, the Board and the Commission should consult on what action should be taken with the body that took the most serious view of a matter prevailing. There is general agreement among submissions that both the Board and the HCCC should be involved in determining what action should be taken.

If **option 2** were adopted the HCCC would have a role not dissimilar to the role it has under the current disciplinary system. The Board and the HCCC would continue to consult each other on

the action to be taken regarding each complaint and if either body considers that a complaint requires investigation by the HCCC it must be so investigated. Decisions to refer matters to the Tribunal or Board for hearing following investigation by the HCCC would be made on a similar basis.

Where a complaint is referred to the Assessment Committee the Board would provide the HCCC with a copy of the Committee's recommendations and notify it of any action taken by the Board. As the Board is the relevant adjudicative body on complaints involving conduct that may constitute unsatisfactory professional conduct, there may be a perceived lack of transparency and a conflict in roles if the Board is able to dismiss a complaint that the Assessment Committee has recommended be the subject of an inquiry into unsatisfactory professional conduct. One option to overcome this problem might be that where the Committee recommends that the Board inquire into unsatisfactory professional conduct the Board must inquire into the matter or refer it to a Tribunal for hearing. In the interests of accountability, in such cases the Board would also be required to notify the HCCC of that action and give it the opportunity to make a written submission to the inquiry/hearing or in Tribunal matters actually conduct the prosecution.

10.6.6 The Department's position

The Department has identified the two models for the purposes of further consultation with stakeholders. It is recognised that the second model has not been the subject of prior consultation.

The Department recommends the second option primarily because it establishes a more consumer focussed and responsive complaints handling system. In particular, it allows for a broader range of complaint matters to be dealt with. In this regard, it is useful to contrast the utilisation of the DCAC with both the current system under the Optometrists Act 1930 and the PSC/Tribunal structure under the Chiropractors and Osteopaths Act. The Dental Board receives around 80 complaints each year and about 80% are referred to the DCAC for consideration.[84] By contrast the Optometrists Board over the period 1991/92 to 1997/1998 received 116 complaints however there were only 5 disciplinary hearings involving professional standards and 24 involving advertising. Again for the seven reporting years 1991/2 to 1997/8 the Chiropractors and Osteopaths Registration Board which has the PSC/Tribunal structure received over 220 complaints and held only one PSC, with 10 matters being heard by the Tribunal.

Further, the experience of the Dental Board is that the DCAC performs a useful function for consumers, responds to claims in a prompt manner, and is a less costly alternative for consumers than pursuing legal action through the courts or tribunals. It represents an effective way of dealing with consumer complaints, the vast majority of which relate to the less serious end of the misconduct scale or to disputes as to whether consumers have received treatment of value.

10.7 Impairment

The Board of Optometrical Registration has also recommended that 'impairment procedures' be established based on the provisions of the Medical Practice Act 1992 and Nursing Act 1991. No reasons have been provided as to why such a system should be established. No other submissions addressed this issue.

---

84 Dental Board of NSW Information Bulletin (October 1997) p.5

Under the Medical Practice Act the Board refers matters relating to physical or mental capacity, or addiction to drugs and alcohol to an Impaired Registrants Panel consisting of medical practitioners. The Panel assesses the practitioner and can impose conditions, with the consent of the practitioner, on their registration. Practitioners that do not consent are referred back through the disciplinary system. The system is designed to encourage practitioners to self-report impairment and take remedial action before patients are injured. It is principally used in matters of addiction to drugs or alcohol.

While the benefits of establishing a non-punitive, rehabilitative system for certain practitioners is clear, the Department is not satisfied that a need has been established to introduce such a system for optometrists. No evidence has been provided to demonstrate there are significant numbers of impaired practitioners who are going undetected. Few complaints have been made to the Board that optometrists are impaired. The complaints structures recommended above could be utilised to consider such cases, without incurring the costs associated with the impairment system.

10.8 Complaints Handling Procedures

The procedures for handling complaints were mentioned above. In addition to those points, the procedures for handling complaints should incorporate the following features.

- Complaints can be made by any person including the Board or the Director-General.
- Complaints are to be made in writing to the Board or the Health Care Complaints Commission (HCA). Either body may seek further particulars from the complainant and must notify the practitioner the subject of the complaint. A complaint need not be pursued where the complainant fails to provide further particulars.
- Complaints made to the Board are to be referred to the HCCC and vice versa. The HCCC and the Board must consult on the complaint (in accordance with the provisions of the Health Care Complaints Act 1993) to see if agreement can be reached between them.
- In accordance with the provisions of the Health Care Complaints Act, the organisation with the more serious view of the complaint prevails. Both the Board and the HCCC are under a duty to refer serious matters (other than matters relating to the physical or mental capacity) to a Tribunal.
- Before referring complaints for hearing, a statutory declaration must be completed by the complainant.
- The Board may direct that a practitioner attend for a medical or psychological examination, and failure to attend could be considered as evidence that the practitioner does not have capacity to practise.
- Inquiries are not prevented by other proceedings, including criminal proceedings.
- Complaints need not be referred if the practitioner is dead.
- Complaints may be withdrawn following consultation between the Board and the HCCC, provided both parties agree.

The Department is of the view these provisions provide an appropriate mechanism for the handling of complaints and should be reflected in legislation.

Recommendation 28 – Dealing with Complaints

That further consultation be undertaken during drafting of legislation to regulate the optometry profession on a revised disciplinary structure whereby:

- An Assessment Committee will be established to consider and investigate complaints, referred from the Board, regarding professional fees and standards of professional services.
- The Assessment Committee will be able to conciliate and investigate consumer complaints and to make recommendations to the Board for the resolution of those complaints or any further action the Committee considers should be taken.
- When a Committee recommends that there be an inquiry into unsatisfactory professional conduct or professional misconduct the Board must conduct an inquiry or refer the matter to the Tribunal for a hearing.
- The Board will hear complaints of unsatisfactory professional conduct following investigation of a complaint by an Assessment Committee, the Health Care Complaints Commission or the Board's own inspector.
- The Tribunal will be required to hear complaints of professional misconduct.
- Procedures are put in place for the handling of complaints based on the provisions of more recent health professional registration legislation.

10.9 Powers of Disciplinary Bodies for the Conduct of Hearings

10.9.1 General powers

The Department sought submissions on the appropriate powers of disciplinary bodies for the conduct of disciplinary proceedings. The Department specifically sought submissions on the issue of whether the provisions for the conduct of proceedings under the Act as set out in Schedule 2 of the Medical Practice Act 1992 are appropriate, particularly in relation to the awarding of costs. These powers and provisions can be summarised as follows.

- Neither body is bound by the rules of evidence.
- PSCs or Tribunals may summons witnesses, subpoena documents and take evidence on oath.
- PSCs or Tribunals may receive and admit into evidence certain material relating to other proceedings.
- PSCs or Tribunals may deal with one or more complaints about a practitioner together, or deal with new matters or grounds for complaint arising during the course of proceedings.
- PSCs or Tribunals may direct, in appropriate cases, that the name of any witness not be disclosed in the proceedings.
- PSCs or Tribunals may direct, in appropriate cases, that the name and address of a witness, complainant or practitioner, specified evidence or the subject matter of a complaint not be published.
- A person appointed by the Commission may act as nominal complainant for the actual complainant.
- The Commission and Director-General of the Department of Health have the power to intervene in proceedings and have a right to be heard (and in the case of a Tribunal may be represented by a barrister or solicitor).
- Matters must be dealt with expeditiously.
- Provisions to enable evidentiary certificates relating to the status of the Register to be tendered in evidence.
- Provisions to enable the discontinuance of proceedings where a practitioner has died or if the person ceases to be registered. Proceedings may be discontinued if the complainant fails to comply with a requirement of the Committee or Tribunal.
- The Tribunal has the discretion to award costs. Costs awards cannot be made by PSCs.

These powers would be adapted for the proposed OCAC/Board/Tribunal structure recognising that the Board would conduct hearings for unsatisfactory professional conduct. A few submissions commented on specific issues.

10.9.2 Power to award costs

The Nurses Association opposes the power of the Tribunal to award costs, on the basis that this is an unjustifiable imposition on practitioners the subject of disciplinary proceedings. The Optometrists Association Australia (NSW Branch) supports such a power as a means of deterring frivolous or vexatious complaints. The Department supports the power of the Tribunal to award costs on this basis.

10.9.3 Access of the public to disciplinary proceedings

Insight Magazine, an eye-care industry newspaper, has submitted that the current requirement in the Optometrists Act 1930 that the board must sit in open court should continue. Insight argues that this enables such matters to be reported and that powers to suppress evidence should not be supported. Insight point to the substantial public benefits of having such matters fully reported so that the public and other professionals are made aware of inappropriate conduct.

It is proposed to adopt a model for access to disciplinary proceedings based on the Medical Practice Act 1992. Under this model:

- Professional Standards Committees are conducted in the absence of the public, unless the committee otherwise directs. Such committees are however required to provide details of decisions to the complainant, the Board and others as it thinks fit, although it may excise certain ‘confidential information’.

- Tribunal matters are conducted in public except where the Tribunal otherwise directs.

Under the OCAC/Board/Tribunal model proposed above the Board would take the place of PSCs for inquiries into unsatisfactory professional conduct.

While the concerns of Insight are recognised, it is the Department’s view that the system under the Medical Practice Act 1992 provides a more appropriate balance between the public’s “right to know” and the interests of the parties involved in a complaint. For example, a complaint about a practitioner relating to their physical or mental capacity to practise could result in highly sensitive and personal information being disclosed. As this would be dealt with by the Board, this material would not be available for the public generally, although a statement released by the Board at the completion of the hearing would generally be made available and would serve the purpose of educating the public. Similarly, suppression powers are necessary in cases before the Tribunal where highly personal information about complainants may be disclosed (for example, the complainants condition).

Recommendation 29 – Powers for the Conduct of Proceedings

It is recommended that the Act regulating the optometry profession include powers for the conduct of proceedings by the Board/Tribunal based on the provisions of Part 11, Part 12 and Schedule 2 of the Medical Practice Act 1992.

10.10 Action Against Practitioners Who Cease to be Registered

The Issues Paper noted that a person the subject of a complaint could ask the Board to remove their name from the Register to avoid disciplinary proceedings. Rather than amending the Act to prevent the Board from removing the practitioner's name, the Issues Paper suggested that the legislation should be clarified so that disciplinary action can continue against a person who ceases to be registered based on sections 40, 58 and 61 of the Medical Practice Act. This proposal was supported because it will ensure that the process for the consideration of applications for re-registration following disciplinary action will apply should the applicant again seek registration. There is wide support expressed in submissions for this position.

Recommendation 30 – Continuance of Disciplinary Action

It is recommended that the Act clarify that disciplinary action may continue against a person that ceases to be registered.

11. ADMINISTRATION OF THE OPTOMETRISTS ACT AND OTHER ISSUES

11.1 Composition of the Board

The Department sought comments in the Issues Paper on the issue of whether the constitution of the current Board is appropriate. Comments were also sought as to whether the mechanisms for appointing or nominating members to the Board are appropriate.

Submissions to the review highlighted a range of issues concerning constitution of the Board, which are discussed below. These are summarised below.

11.1.1 Increase in the size of the Board

The OAA (NSW) has argued for an increase in the size of the Board from seven to nine.[85] While this would undoubtedly result in higher costs through payment of fees to Board members, it would also allow a broader range of interests to be represented on the Board, including consumer and public representatives. Further, it would allow the workload of the Board to be spread more evenly among members.[86]

The Department supports this change.

11.1.2 Optometric representation

In increasing the number of Board members, the OAA (NSW Branch) argued that additional two nominees should be provided by the OAA, while the Opticians and Optometrists Association should no longer nominate a board member. The OAA argues that the latter association only has about 20 members while the OAA (NSW) represents 92% of the profession. This would mean four registered optometrists would be nominated by the OAA with another registered optometrist nominated by the UNSW, making a total of five registered practitioners, a majority of the Board.

OPSM Ltd argues the contrary position:

> *"OAA now proposes there be an increase in the Board's numbers to nine, for no other apparent reason to strengthen its control of all matters optometric...*
>
> *Clearly the effect, if not the intention, of such a Board is to continue to restrict and control in unacceptable detail, the normal business operations of optometrical companies and to hinder the normal decision making powers of the Minister, who can currently not act on ownership matters unless it is on the recommendation of the Board....*
>
> *OPSM believes a more balanced Board is essential and that it should include a representative of all sections of the optometry and optical dispensing professions as well as consumer, legal and medical representatives.*

The Department supports the principle that the Board should have a sufficient mix of nominees to enable it to carry out its functions. In light of the recommendations made earlier in this Report, it is clear that the primary functions of the Board are to register new applicants for practice, to make

---

85 Submission of the Optometrists Association of Australia, NSW Branch at page 56

86 ibid.

decisions in relation to complaints and disciplinary action and provide advice on matters affecting the profession generally. As is the case with other health professional registration boards, it is necessary to have a majority of optometric members on the Board to enable it to carry out these functions.

However, the concerns of OPSM are noted. Where the Board has the authority to make decisions that affect the commercial practices of optometrists or other service providers, it is critical that there is an appropriate mix of non-optometric board members to ensure transparency.[87] This is provided for by recommendations made below. An argument could be made that the profession regulated by the Board should not have a majority of members because the potential exists for the provisions to interpreted in favour of the profession. However, the Department is of the view that the new legislation will provide for substantial accountability mechanisms to ensure that this does not occur.

The nomination of optometric members is an important consideration. While it is clear that the OAA represents an overwhelming majority of optometrists, it is questionable whether that association should be given a legislative monopoly on appointment of Board members. New associations may emerge which could seek such a role in nomination of board members. Further, legislative recognition of direct nomination by a specific association may tend to reinforce a view that the nominees are appointed to represent the interests of the nominating association. Clearly, Board members have a duty to serve the interests of the Board as a whole and not those of the association. Alternative processes may be available to ensure that a better and fairer mix of nominees can be appointed.

To overcome this problem, the Department supports an approach whereby relevant professional associations provide names generally, from which the Minister selects appropriate appointments.

11.1.3 Medical practitioner

The OAA (NSW Branch) submitted that the medical practitioner should be removed from the Board, as has been the case for other health professional boards. RACO, the Nurses Association and OPSM argue that a medical representative should continue to be placed on the Board given the expanding role of optometrists in relation to drugs.

It is the Department's view that appointment of a medical practitioner to the Board is no longer considered appropriate. While concerns about the expanded therapeutic role of optometrists are noted, decisions regarding the scope of that role and the training required will be made by the Minister who can seek medical advice directly from the Department or medical associations or colleges.

11.1.4 Optical dispenser representation

The Optical Dispensers Licensing Board and Australian Dispensing Opticians Association argue that an optical dispenser should be appointed to the Optometrists Board to facilitate communication and because "an optometrist sits on the optical dispensing board".[88] The Department does not support this change, as communication should occur between the two bodies

---

87 In light of the recommendations made above, the restrictions on ownership and the Minister's approval power under the current Act would be removed minimising the role of the Board in the area.

88 Submission from the Australian Dispensing Opticians Association dated 11 August 1998 at page 6.

without the need for a reserved position on the Board.

11.1.5 Community representation

There is strong support for community representatives on the Board among submissions. Accordingly the Department supports appointment of two community representatives to the Board.

11.1.6 President and Deputy President

The OAA (NSW Branch) has suggested that the Act should make provision for the appointment of both a President and a Deputy President, and that both should be required to be registered optometrists. Other health professional registration acts make provision for such appointments, although normally only the position of President is reserved for a registered practitioner. The Department is of the view that no justification has been provided demonstrating why both positions should be reserved for registered optometrists.

Recommendation 31 – Composition of the Board

It is recommended that the Optometrists Registration Board be constituted as follows:

- Four registered optometrists selected by the Minister from nominations provided by optometric professional associations or by other interested parties;
- One registered optometrist selected by the Minister from nominations provided by universities providing optometric education in NSW;
- One barrister or solicitor nominated by the Minister;
- One officer of the NSW Department of Health or area health services nominated by the Minister; and
- Two people (not being registered optometrists) to provide a consumer and community perspective.

Recommendation 32 – President and Deputy President

It is recommended that the Act provide for appointment of a President (who must be a registered optometrist) and Deputy President as provided for in other health professional registration Acts.

11.2 Tenure of Board Members

The Issues Paper considered the issue of whether the terms of Board members should be limited to ensure that new people are able to obtain appointment to the Board. While such people would be able to contribute alternative ideas, this concern needs to be balanced with the need to obtain experience on the Board. The Medical Practice Act 1992 provides a limit of three as the number of four-year terms that can be served. The Department has recently recommended that that Act be amended to reduce the number of four-year terms that may be served to two.

The Board of Optometrical Registration, the Optometrists Association of Australia, the Optical Dispensers Licensing Board and the NSW Nurses Association supported introduction of limitations. Only the Australian Dispensing Opticians Association opposed such limitations.

Recommendation 33 – Tenure of Board Members

It is recommended that the Act limit Board members to serving only three consecutive three-year terms.

11.3 Sub-Committees

Currently the Board has no power to establish subcommittees or pay members that sit on such committees. Such a power would significantly assist the Board in carrying out its functions.

Recommendation 34 – Sub-Committees

It is recommended that the Board be empowered to establish sub-committees consisting of both Board members and non-Board members and that members of such committees be entitled to be paid.

11.4 Education and Research Account

Within the Issues Paper, consideration was given to the inclusion in the Act of provisions to allow the Board to establish an Education and Research Account (ERA). This account would give the Board the opportunity to develop areas of practice in the profession, to conduct research into problem areas for professionals, to facilitate new directions in education and training, and to fund education programs for the profession and consumers.

The Board of Optometrical Registration, the Optometrists Association of Australia and the NSW Nurses Association supported establishment of such an account.

Despite the presence of such benefits, there may be a potential negative impact of funding the ERA, via a compulsory levy attached to professional registration, on competition in the profession. That is, funding the ERA in this manner may reduce competition by:

- discouraging practitioners, professional associations or other parties from undertaking additional education and research, thereby potentially reducing innovation in the practice and application of optometry; and
- imposing costs on individuals for which they do not consider they receive an adequate benefit.

However it is the Department's view that there are over-riding public interest benefits to support the establishment of such an account. The intent of such provisions is not to encourage research into products which will deliver 'private' benefits for individual optometrists or optical suppliers. It is the Department's intention that funds in an ERA would be directed towards conducting research into issues such as standards among professionals, rates of adverse events, drug use among practitioners and other professional issues which relate to the provision of safe and effective services to the public. Alternatively, funds could be directed towards educating consumers about the provisions of the Act including their right to make complaints. Submissions highlighted the lack of information available to consumers to assist them to make informed decisions when seeking services.

It should be recognised that the profession will bear the cost of this initiative through registration fees and the profession may argue that the benefit that they derive from such a system does not

justify the proportion of the registration fee dedicated for this purpose. Although individual practitioners may not derive a direct benefit from such a system, it also needs to be recognised that such a system delivers wider benefits to the profession and the community and assists in achieving the objectives of the legislation (that is protection of consumers from harm). It is the Department's view that the costs of such a system on individual practitioners would be substantially outweighed by the public benefits.

Recommendation 35 – Education and Research Account

It is recommended that Act provide for the establishment of an Education and Research Account.

11.5 Other Issues

Issues raised by the Department

The Department sought submissions on the appropriateness of regulatory requirements in the following areas:

- Mandatory professional indemnity insurance;
- Record keeping;
- Mandatory disclosure of fees.

Although generally supported in submissions, it is the Department's view that these matters are more appropriately dealt with in the code of conduct made under the Regulations.

Ownership of records

The OAA has submitted that the Act should include a provision to clarify that ownership of a record rests with the practitioner or the employing practitioner. However, the rationale for such a provision has not been set out by the Association.

Attendance at a practice

The Board and the OAA have argued that a requirement should be introduced so that practitioners who allow their name to be associated with a practice must be in attendance at that practice at least one day a week. While both organisations suggest that this practice is inappropriate, neither sets out the reasons why this is inappropriate. In light of the recommendations made above concerning the ownership of practices, the Department is of the view that this becomes irrelevant.

Foreign body removal and first aid

Both OAA and the Board argue that the Act should not restrict either of these services from being provided by optometrists. The recommendations in this Report are consistent with these comments and no special provision is necessary.

APPENDIX A – TERMS OF REFERENCE

1. The New South Wales Department of Health will review the Optometrists Act 1930 in accordance with the terms for legislative review set out in the National Competition Principles Agreement. The guiding principles of the review are that legislation should not restrict competition unless it can be demonstrated that:

   (i) the benefits of the restriction to the community as a whole outweigh the costs; and

   (ii) the objectives of the legislation can only be achieved by restricting competition.

2. Without limiting the scope of the review, the Department shall:

   (i) clarify the objectives of the legislation and their continuing appropriateness;

   (ii) identify the nature of the restrictions on competition;

   (iii) analyse the effect of the identified restrictions on competition on the economy generally;

   (iv) assess and balance the costs and benefits of the restrictions; and

   (v) consider alternative means for achieving the same results including non legislative approaches.

3. When considering the matters in (2), the review should also identify and consider potential problems for consumers seeking to use optometric services (that is, market failure), which need to be or are being addressed by the legislation.

4. In addition to considering the matters identified above, the Department will consider:

   (i) the effectiveness of the current Act, in particular registration requirements and disciplinary arrangements; and

   (ii) consistency with the Health Care Complaints Act 1993.

5. The review shall consider and take account of relevant regulatory schemes in other Australian jurisdictions, and any recent reforms or reform proposals, including those relating to competition policy in those jurisdictions.

6 The review shall consult with and take submissions from the profession, relevant industry groups, Government and consumers.

APPENDIX B – LIST OF SUBMISSIONS TO THE REVIEW

Submissions Received in Response to the Issues Paper

Australian Dispensing Opticians Association (NSW)
Council on the Ageing (Inc)
Dr Ralph Higgins, Ophthalmic Surgeon
Health Care Complaints Commission
Health Insurance Commission
Insight Magazine
Medical Benefits Fund Ltd
Medical Services Committee
New Children's Hospital
NSW Board of Optometrical Registration
NSW College of Nursing
NSW Department of Fair Trading
NSW Guardianship Tribunal
NSW Health Funds Association
NSW Nurses Association
NSW Optical Dispensers Licensing Board
NSW Physiotherapists Registration Board
OPSM
Optometrists Association Australia (NSW)
Optometrists Registration Board of Victoria
Orthoptic Association of Australia Inc
Peter Freeman, Optometrist
Royal Australian College of General Practitioners
Royal Australian College of Ophthalmologists
South Eastern Sydney Area Health Service

Submissions Received Following Circulation of Submissions

Australian Association of Dispensing Opticians
NSW Optical Dispensers Licensing Board
Open Training and Education Network
OPSM
Optometrists Association Australia (NSW)
Orthoptic Association of Australia
Royal Australian College of Ophthalmologists
Sydney Institute of Technology

APPENDIX C – ECONOMIC EVALUATION BY ACIL CONSULTING

Regulatory options for the NSW Optometric industry - Economic evaluation

A Report to NSW Department of Health

July 1998

Prepared by

ACN 058 284 521

CANBERRA OFFICE

ACIL House
103-105 Northbourne Avenue
Canberra ACT 2601

telephone +61 2 6249 8055
facsimile +61 2 6257 4170

SYDNEY OFFICE

2nd Floor, Oracle Plaza
181 Miller Street
North Sydney NSW 2060

telephone +61 2 9957 6363
facsimile +61 2 9957 1805

BRISBANE OFFICE

Level 15
127 Creek Street
Brisbane QLD 4000

telephone +61 7 3236 3966
facsimile +61 7 3236 3499

MELBOURNE OFFICE

Level 50
101 Collins Street
Melbourne VIC 3000

telephone +61 3 9653 9337
facsimile +61 3 9653 9485

Economics • Policy • Strategy

Executive summary

The Optometrists Act 1930 is under review and an economic evaluation of options is required

ACIL Consulting has been engaged by the NSW Department of Health (the Department) to undertake an economic appraisal of the options for regulation of the industry under the Optometrists Act 1930, pertaining to registration, practice and ownership.

A range of key stakeholders were consulted to determine impacts. This was not part of the wider consultation process which has been undertaken as part of the review, a process which has led to the preparation and release of an *Issues Paper.*

7 registration & practice options and 3 ownership options are separately evaluated

Registration & Practice regulatory options

7. **Title and Whole of Practice Restriction** - existing base case.

6. **Title and Practice Restriction with Exemptions** - as base case with the exception that orthoptists are not restricted in the prescription of glasses. To deal with the educational issue under this option, two sub-options were created:
   Option 6a - Orthoptists are not restricted in the prescription of glasses and contact lenses with their existing qualification.
   Option 6b - Orthoptists are required to undertake an additional course (accredited by the relevant authority) to be granted the exemption for prescription of glasses and contact lenses.

5. **Title and Core Practice Restriction** - core practices, such as the fitting and prescribing of contact lenses and glasses, be restricted to optometrists and medical practitioners.

4. **Title Regulation -** only certified practitioners would be permitted to use the title "optometrist".

3. **Voluntary Certification -** individual practitioners would be certified by a government authority or statutory body.

2. **Co-regulation** - government to monitor the behaviour and standards of the professional association to ensure it operates in the public interest.

1. **No/Self Regulation** - repeal the current Act and install a system of no regulation, or self regulation through practitioners holding voluntary membership of a professional association.

Ownership options

A. **Maintain Current Ownership Restrictions** - base case

B. **Restricted Incorporation and Ownership -** optometrists would be permitted to form corporate bodies under the proviso that the optometrist retains the majority of the share holding.

C. **Unrestricted Ownership** - this would permit the establishment of corporate bodies with no restrictions on ownership.

The scope of the evaluation is restricted.

It should be noted that:

- the scope of the evaluation excludes the issue of use of therapeutic drugs, and
- did not consider options outside those provided by the Department
- there are linkages between ownership and practice regulation options, so although analysed separately, we have incorporated these linkages as appropriate
- conclusions can be regarded as only indicative given the lack of data available for impact estimation and the approximate estimation methods used.

Two clear issues were raised by stakeholders, and conflicting views expressed:

- Orthoptists wish to be able to prescribe glasses, and are willing to undergo additional training if required.
- Optical Dispensers wish to be allowed to own optometrical practices and employ Optometrists.

These issues have been incorporated into our analysis.

The costs and benefits have been analysed under the following categories:

- Compliance impacts
- Administration impacts
- Resource allocation impacts
- Competition policy impacts.

Results

The trade-off between competition benefits and public health risks is the key to ranking options

The results of the impacts identified and assessed either quantitatively or qualitatively for Options 1-7 are shown in the table overleaf:

The key results from this analysis are:

- The current system (Option 7), Option 6a, Option 5 and Option 1 rank equivalently in terms of lowest quantified costs. However, overall the differences in quantified costs are not particularly significant between the options, and cannot be used alone as deciding between the options.
- Qualitative analysis indicates that Option 5 is effectively equivalent to the base case for unquantified impacts, with few benefits from competition, and a negligible increase in public health risks

- Option 1, which is equivalent to the base case and Option 5 on a quantified cost basis, has public health risks associated with it of medium significance, but also has potentially significant benefits from competition.
- Option 6b (orthoptists upgrade qualification) avoids any increase in health risk and has benefits from competition which more than offset higher educational costs.

Summary results: Options 1-7

$ 000 p.a. **1998 prices** unless otherwise stated	**Base** **7**	**Title/ Exempt (no upgrade)** **6a**	**Title/ Exempt (upgrade)** **6b**	**Title/ Core** **5**	**Title** **4**	**Certif** **3**	**Co-Reg** **2**	**Self/No** **1**
Quantified Costs **Administration**	135	135	135	135	128	135	88	40
Compliance	72	72	72	72	72	72	72	72
Disciplinary	27	27	27	27	27	45	45	45
Educational	0	0	100	0	100	100	100	100
TOTAL	234	234	334	234	327	352	305	257
Incremental costs v. base case	0	0	+100	0	+93	+118	+71	+23
Unquantified costs **Health risk factor (0-10 scale)**	0	5	0	0	5	8	8	10
Benefits - Cost savings **Significance** **$ 000 assumed**	None 0	Low 500	Low 500	Marginal 100	Low 500	Medium 2,250	Medium 2,250	Medium 2,250

A threshold analysis is undertaken to assist option ranking

The threshold analysis attempts to determine what the unquantified impacts across the options would need to be valued at to achieve equality with the base case:

- compared with the existing average consultation fee for optometrical consultations ($45), the range of threshold values for potential health risk impacts is low - from zero in the base case to under $2 in the most deregulated option.
- although this is indicative analysis, it does indicate that any health risk impacts of the deregulated options (1-3), would not have to be valued particularly highly on a per service basis for those impacts to outweigh any cost saving benefits from increased competition.

Ownership options - evaluation

Deregulation of ownership is expected to confer net benefits

Ownership option B was not analysed further on the grounds that its key impacts - tax advantages are no longer available. In effect, we are only considering two ownership options - the existing restrictions(A) against a fully deregulated system (C). In our consultations strong arguments have been advanced to us at either end of the ownership debate.

Our observations in evaluating Options A and C are:

- Limitation of ownership is a blunt instrument in regard to impacts which can be dealt with under practice regulation options. Public health risk impacts are more properly dealt with under the practice provisions of the regulatory options.
- Under all practice regulation options, disciplinary processes will be in place to deal with any trade-offs between commercial incentives and professional practice standards
- Under deregulated option C, there should still be incentives for professional standards to be upheld, assuming the provisions under Options 1-7 effectively prevent increased health risks in the practice of optometry.

Conclusions

Conclusions can be drawn but lack of data means that they should be treated as indicative

The following conclusions can be drawn from the analysis presented in this report:

Practice regulatory options:

- the conclusion from our analysis is that Option 6b (title regulation with exemption for orthoptists who have upgraded their qualifications) is the option likely to confer highest net benefit on the NSW community.

  This conclusion must be tempered by the lack of data available for the analysis and the indicative nature of the estimation procedures used.

Combining regulatory option 6b with the deregulated ownership Option C, appears to confer highest net benefit

Ownership options:

- The conclusion for ownership options depends on the practice regulatory provisions in Options 1-7. On balance, this analysis concludes that the risks of deregulated ownership are likely to be outweighed by the benefits to the consumers, given that a regulatory system continues on the practice of optometry.

Competition principles:

- The costs and benefits of the options have been assessed including indicative analysis of competition impacts. The public benefits test has been applied using the cost benefit framework.
- This concludes that continued regulation on the registration and practice of optometry is likely to be in the public interest, but in combination with deregulated ownership to gain the key benefits from increased competition.

APPENDIX D SUMMARY OF LEGISLATION REGULATING OPTOMETRY IN OTHER JURISDICTIONS

	Register	Board	Restricts title	Restricts Practice (whole or core) *	Restricts Advertising	Restricts incorporation	Restricts ownership	Restricts access to diagnostic drugs	Restricts access to therapeutic drugs
NSW	yes	yes	yes	whole	yes	yes	yes	yes	yes
ACT	yes	yes	yes	whole	no	no	no	no	no
NT	yes	yes	yes	whole	no	no	no	yes	yes
QLD	yes	yes	yes	whole	Regulation making power	no	yes	no	no
SA	yes	yes	yes	whole	Regulation making power	no	no	no	yes
TAS	yes	yes	yes	whole	yes	no	yes	no	no
VIC	yes	yes	yes	whole	yes	no	no	no	no
WA	yes	yes	yes	whole	no	no	no	yes	yes

* ***Whole of practice*** restriction means the Act contains a definition of *optometry* or *the Practice of optometry* and then restricts the practice to registered persons and others who are expressly exempted. ***Core practice*** restriction means the Act does not contain a definition of *optometry* or *the practice of optometry* but contains provisions which restrict the practise of certain core functions.

APPENDIX E COMPLAINTS RELATING TO OPTOMETRISTS

(i) Complaints handled by the Board of Optometrical Registration

YEAR	TOTAL	Treatment	Prescribing patterns	Advertising	Business practises	Professional conduct	Impair-ment
1990/1	17	1	0	16	0	0	0
1991/2	36	2	9	25	0	0	0
1992/3	23	1	0	18	2	2	0
1993/4	9	3	0	4	0	2	0
1994/5	16	11	0	5	0	0	0
1995/6	11	10	0	1	0	0	0
1996/7	14	4	0	8	0	1	1
1997/8	7	0	0	3	0	1	0

(ii) Complaints Received by the Health Care Complaints Commission

YEAR	Total
1994/5	16
1995/6	9
1996/7	5
1997/8	4

(iii) Disciplinary Inquiries under s.15 of the Optometrists Act 1930

YEAR	Total	Treatment	Medicare offences	Advertising	Professional conduct
1990/1	10	0	2	8	0
1991/2	11	0	0	11	0
1992/3	9	0	0	9	0
1993/4	4	0	0	3	1
1994/5	1	0	0	1	0
1995/6	1	0	1	0	0
1996/7	2	1	1	0	0
1997/8	1	0	1	0	0

(iii) Complaints received by the Department of Fair Trading - 1 January 1997 to 29 July 1998

Complaints	Number
Total	19
Unsatisfactory Repair	1
Unsatisfactory Performance of a Product	3
Unsatisfactory Performance of a Service	3
Unsatisfactory Advice	1
Defective Goods	3
Non-completion of Service	2
Disputed Account/Charging	3
Damage to Property	1
No Refund	2