“Protecting the Public Interest: A Review of the Northern Territory Professional Boards”

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EXECUTIVE SUMMARY

The rationale for all occupational regulation is the protection of the public interest. While this concept is somewhat amorphous, it is generally understood to imply that the community has a need to be protected from activities which, if undertaken by an inappropriately educated person, may pose a serious potential for harm to the mental or physical wellbeing of the community. This public protection rationale is premised on the belief that regulated professionals deliver safer and higher quality health care and thereby minimise the personal, economic and social consequences of inappropriate and unsafe health care practises.

Contemporary views of professional regulation hold that the public's interest could be best served by ensuring that regulatory frameworks:

- Go beyond initial assessment for registration to ensuring continuing competence of practitioners;

- Promote effective health outcomes and protect the public from harm;

- Are accountable to the public;

- Respect consumer's rights to choose their health care providers from a range of safe options and facilitate consumers to be knowledgeable managers of their own care; and

- Encourage a flexible, rational and cost-effective health care system that allows effective and evolving working relationships among health care providers.

Professional regulatory frameworks therefore need to be developed so as to allow for mechanisms that not only ensure appropriate and effective standards of care, but also individual practitioner competence.

A register of professionals is a document, which informs the public which practitioners have satisfied the requirements to use a registered title. It is an assurance that at the time of his or her initial registration, a practitioner had completed the requirements demanded by the Board and was educated to engage in the activities of the profession. It does not guarantee that the person has, or will continue to, maintain the necessary competence to practise safely.

As the basis for the regulation of health care practitioners is the issue of the potential for public harm, there is no pure legislative reason for regulating an occupational group unless such risk exists and that there is no other less restrictive manner of minimising the risk. On this basis, it is recommended that Aboriginal Health Workers, Chiropractors, Dentists, Medical Practitioners, Midwives, Nurses, Occupational Therapists, Optometrists, Osteopaths, Pharmacists, Physiotherapists and Podiatrists be regulated by specific health care practitioner legislation. It is further recommended that dental auxiliary workers such as Dental Hygienists and Therapists, not be individually regulated but that certain aspects of their practise be regulated. It is also recommended that the regulation of Radiographers and the issuing of licenses for radiographic purposes, be included in the provisions of the *Radiation Safety Control Act 1978*.

Successive inquiries into "professional governance" have recognised that the statutory establishment of a regulatory Board, with a membership drawn either entirely or mainly from a particular peer group, is effectively a limited delegation of State power to that peer group to regulate its own. While this delegation is necessary, it is essential that the legislative model of delegation of power ensure that the public's interest is paramount and provides maximum accountability to the public. This system differs from what is normally termed "self-regulation" because the membership and functions of a Board are set down in legislation and not determined by the health practitioner group alone.

When considering any future model for the Professional Boards, there are several key issues, which need to be addressed:

- The costs and benefits associated with any model;
- The need to ensure a responsive support service is available to the Boards;
- The context of the Northern Territory;
- The need to ensure public accountability;
- The extent to which the Boards should be independent of Northern Territory Health Services; and
- The level of public funding.

While a range of options may exist including maintenance of the status quo or creating autonomous administrative arrangements for each Board, it is recommended that the most viable option in terms of fiscal efficiency, effectiveness and accountability is that of a centralised independent authority responsible for the administrative support of all Professional Boards. In addition to the fiscal efficiencies that such a model brings, a centralised administration can facilitate the co-ordination, consistency and public accountability of the whole Professional regulatory system. Such an authority would be directly responsible to the Parliament through the Minister for Health and Community Services. It is recommended that this authority be titled the Health Professions Authority.

Greater involvement by consumers in the professional regulatory process is a key mechanism to improving consumer knowledge and faith in the regulatory systems and of demonstrating public accountability. For this reason, it is incumbent on Boards to find creative ways for genuine public involvement in debate on regulatory policy, including appropriate and effective membership by consumers on professional Boards. Recommendations 32 to 38 deal with this issue.

Health professionals practise in a health care environment that is characterised by constant and rapid change. Advances in science and technology; restructuring of service delivery; increasing demands on limited fiscal resources, and changing community needs are continuously influencing the practise environment. These changes coupled with increasing consumer awareness, provide an increased impetus for practitioners to continue to develop their knowledge and skills to ensure they safely and effectively meet the public's need.

The introduction of legislative provisions to ensure continuing competence of practitioners is therefore essential in any future regulatory legislation. Such provisions are a proactive means by which the public can be assured, as far as is practicable, that those individuals who hold a current licence to practise are competent to do so. Viewed alternatively from a quality management perspective, it is a regulatory process to ensure quality. Legislative provisions would act in harmony with both an individual's responsibility to ensure they do not undertake activities for which they are not competent and an employer's common law duty to ensure that no employee is employed to undertake activities for which they are not competent. These "quality" checks within the broader health care system operate as a means of ensuring the *protection of the public interest*.

One of the key responsibilities of Professional Boards is that of investigating complaints about practitioners. Increasingly, Boards are criticised by consumers for their management of this aspect of regulation.

The AHMAC Quality in Australian Health Care Study highlighted consumer concerns in this area and lead to the recommendation that a review of Professional Boards be undertaken.

Consumer criticisms of Boards in terms of complaint management generally fall into four categories.

1. Inadequate public information about the complaints process.
2. Inadequate information regarding the progress or outcomes of complaints.
3. Reluctance of Boards to pursue allegations of practitioner misconduct or incompetence.
4. Lack of responsiveness in resolving complaints.

A review of the current complaints management processes that exist within the Professional Boards has identified that there exists room for improvement in terms of categories 1, 3 and 4. Recommendations 49 to 63 have been made to address these areas.

In most jurisdictions of Australia, save the Australian Capital Territory, professional regulation is predominantly self funding. This is achieved through income generated by the number of practitioners that practise in the jurisdiction. The size, demographics, and locale of the Northern Territory militates against a self funding regulatory system operating in the short term although this should, in principle, be the long term aim.

Examination of the current situation has identified that, discounting the fees received into consolidated revenue, Government, through Territory Health Services, currently contributes approximately $350,000.00 per annum to the operation of the Professional Boards. The complexity of managing regulatory functions effectively, including the issue of ensuring ongoing competence of practitioners, investigations of complaints and disciplinary actions, managing impaired practitioners, and meeting increased community expectations, requires Boards to be responsive, proactive and innovative in developing approaches to ensuring safe practise. The current structure does not facilitate such an arrangement and therefore a revised organisational structure, included in Appendix C, has been recommended.

Given the circumstances of the Northern Territory, this structure would still require the support of Government to operate and it is recommended that this occur by way of Government providing an annual grant of $400,000.00 to the Professional Boards. This grant, coupled with the fees received as per the recommended schedule of fees, would see the Professional Boards function independent of Territory Health Services. It is further recommended that the level of this grant be reviewed 3 years after the commencement of the new legislation with the long term view that the Professional Boards be self funding.

To further facilitate the openness and responsiveness of the health care system to change and community demands, it is recommended that any future legislation only regulate health care practitioner titles and not health care practises, and that the Health Professions Authority, in conjunction with the Professional Boards, be legislatively required to provide recommendations to the Minister on a future model for health care practises' regulation utilising a public protection focus. This approach recognises that

health service delivery occurs in a rapidly changing and developing society and that, in concert with society, treatment modalities and contexts will change and the professions must evolve to meet these changes.

RECOMMENDATIONS

1. That any future legislation developed for health professional regulation be consistent in the use and application of terminology.

2. That the public interest purpose of professional regulatory legislation be clearly defined in any future legislation developed.

3. That the requirements for entry to practise as a health professional in the Northern Territory be standardised to three broad criteria; (1)Fitness to Practise, (2) Competence to Practise, and (3) Completion of an approved course.

4. That there be no criteria of Northern Territory residency, or intention to do so, as a requirement for registration as a Health Professional in the Northern Territory.

5. That any legislation be constructed so as to allow for three categories of registration – Full Registration, Interim Registration and Conditional Registration.

6. That determination of area of need is the responsibility of the Minister assigned responsibility for the Act.

7. That legislative provision be included in any new Act to allow the professional boards the power to accredit courses leading to entry to the register.

8. Entry to the register should be limited to the initial qualification for practise, however provision should be made for health practitioners to have their specialist qualifications noted on the register.

9. That a register be maintained for Aboriginal Health Workers, Chiropractors, Dentists, Medical Practitioners, Occupational Therapists, Optometrists, Osteopaths, Pharmacists, Physiotherapists, and Psychologists.

10. That a register be established for registered nurses and midwives and that a roll be established for enrolled nurses.

11. That a register for Podiatrists be established in the Northern Territory and that the Podiatrists be included in a combined Board with the Chiropractors and Osteopaths.

12. That the Radiographers Board be disbanded and that the future regulation of Radiographers be incorporated into the provisions of the *Radiation Safety Control Act 1978*.

13. That pending the amendment of the *Radiation Safety Control Act 1978* to incorporate the above recommendation, and the establishment of a satisfactory process, the *Radiographers Act* not be repealed.

14. That Dentists and Chiropractors be exempted from requiring a license pursuant to the *Radiation Safety Control Act 1978*.

15. That legislation regulating the practise of Dentistry and Chiropractic make provision for these practitioners to undertake limited radiographic procedures and that a license to practise as a Dentist or Chiropractor, as the case may be, be sufficient authority for these practitioners to undertake that practise.

16. That the authority for issuing of permits to medical practitioners and other health care practitioners be incorporated into the *Radiation Safety Control Act 1978*.

17. That the *Radiation Safety Control Act 1978* require persons applying for a license or permit to operate radiographic equipment to, in addition to possessing appropriate educational qualifications, be a fit and proper person.

18. That ancillary Dental Workers, such as Dental Hygienists and Therapists, not be registered as a separate category but that the Dental Board have the legislative power to authorise these and other classes of persons, by regulation, to undertake dental activities which, if undertaken by an inappropriately educated person, may pose a serious potential for harm to the mental or physical wellbeing of the community.

19. That all Professional Boards, through regulation, have the legislative power to grant an authority for other classes of persons to undertake activities restricted to a professional group where there is a public need and the public's safety can be assured.

20. That Board's primary functions be:

- To assess applications for registration and register persons who meet the requirements for registration.
- To maintain a register.
- To ensure that registrants continue to maintain competence and comply with conditions of registration.
- To provide guidance to the profession on clinical, conduct and ethical matters.
- To publish and distribute information pertaining to the Act to the public, the profession and other interested parties.
- To receive complaints about registrants, initiate investigations into complaints and other matters as prescribed in the Act.
- To accredit courses leading to entry to practise.
- To endorse continuing education programs.
- To participate in any national or other body concerned with national policies for the regulation of the profession.
- To advise the Minister on matters related to the profession.

21. That an independent statutory authority called the Health Professions Authority be established to administer the Professional Boards.

22. That the Health Professions Authority be subject to normal public accountability processes such as the Ombudsman's Act, and any public sector management standards.

23. That the Minister's powers in relation to the Health Professions Authority and the Professional Boards be made explicit in the enacting legislation and include the power to require reports and information from the Authority or a Board, to notify the Authority or a Board of public sector policies and require them to be followed, to make funds available to the Authority or a Board by way of loan or grant and to waive repayment, and to require the Authority to provide the Minister with an annual report of the Authority's and the Board's activities including financial statements.

24. That following the implementation of REGIS, the current processes for registration be reviewed with the aim of simplifying and streamlining the current administrative process.

25. That legislative provisions be enacted that allow Boards to delegate the authority to the Registrar for registering persons who comply with the requirements of the Act.

26. That Boards adopt a governance approach to registering practitioners and develop policy that authorises the Registrar to register those practitioners that meet the delineated requirements of policy.

27. That there be two staff specifically devoted to registrations for all Professional Boards; one registrar and one deputy registrar.

28. That the annual licence renewal date for all practitioners be moved to a common single date.

29. That three Research/Policy Officers be employed to provide policy development support to the Professional Boards.

30. A Complaints Officer be appointed to undertake investigations and manage the Professional Boards complaints process.

31. That the organisational structure contained in Appendix C be implemented.

32. That all Professional Boards have at least two consumer members included in their membership.

33. That an adequate orientation and resources be provided to support both consumers and practitioners in their role as members of professional Boards.

34. That all appointments to Professional Boards be made by the Minister for Health and Community Services and not be based on ex-officio appointment.

35. That in making appointment to Professional Boards, the Minister should have regard to gender, social and racial background.

36. That the size of the membership of the Medical and Nurses Board be seven and that the size of the membership of the remaining Professional Boards be five.

37. The composition of Professional Boards be limited to two consumer representatives and practitioners who hold a current licence to practise in the relevant profession in the Northern Territory. In making appointments, the Minister should give regard to ensuring the broadest possible expertise in the membership.

38. That a consumer representative be permitted to hold an appointment as a member of more than one Professional Board concurrently.

39. That the Chair of any Professional Board be a practitioner and that they are appointed by the Board on the basis of an election held among the members.

40. That the legislation provide that the Board may appoint a temporary Chair in the absence of the appointed Chair.

41. That members of Professional Boards who are not public servants be entitled to a stipend of $100.00 per meeting, regardless of duration.

42. That the Professional Boards develop processes for informing consumers about the role and function of Professional Regulatory Boards including the availability and mechanism of the complaints process.

43. That the Professional Boards develop processes for ensuring consumer involvement in debate on regulatory policy

44. That provision be made in future legislation to enable Professional Boards to provide consumers with information about practitioners licence status, educational background, and any civil, criminal or disciplinary judgement.

45. That the Professional Boards implement measures to inform practitioners of the role and function of Boards and to provide practitioners with information of Board's activities including outcomes of formal disciplinary processes.

46. That the Professional Boards continue to assist, on behalf of the Northern Territory Government, the Australian Institute of Health and Welfare to collect labourforce data.

47. That consideration be given to utilising the Professional Boards to collect Northern Territory specific data from designated health professional groups to assist Government in labourforce planning.

48. That legislative provisions be implemented that would allow Boards to require practitioners to provide evidence of their continuing competence prior to licensure and re-licensure. In order to ensure that such processes remain contemporaneous, the mechanisms for achieving this should be left for Boards to introduce via policy.

49. That information in terms of complaints received and outcomes be published in the Boards annual reports.

50. That a two level process for the management of complaints be implemented legislatively so as to allow Boards to both deal with practitioners who have been identified as being at high risk for poor performance but whose conduct or competence does not meet the common law definition of professional misconduct, and those practitioners whose conduct or competence may constitute professional misconduct.

51. That the term professional misconduct be legislatively given an extended meaning to include a breach of a by-law of the Board, a breach of an undertaking given to the Board, contravention of the Act or a condition subject to which the practitioner may practise, or being fraudulent, dishonest, negligent or incompetent in professional practise.

52. That an independent Professional Review Tribunal, composed of 1 legal practitioner of greater than ten years standing as Chair and a consumer representative be established to hear formal matters referred by a Board against a health practitioner.

53. That the Professional Board referring a matter of professional misconduct to the Professional Review Tribunal be responsible for appointing three peers to sit with the two permanent members for the purpose of the hearing.

54. That the Board, a complainant, or a practitioner may appeal against a decision of the Professional Review Tribunal and that these appeals are to the Supreme Court.

55. That the Professional Review Tribunal also be given the power to hear appeals against any decision of a Board.

56. That the Professional Review Tribunal be given broad powers of sanction including, but not limited to, removal from the register, imposition of conditions on practise, order a practitioner to undertake or refrain from undertaking specified action, suspension of a practitioner's right of practise for a period or impose a monetary fine.

57. That the Professional Review Tribunal be given the power to order a practitioner to pay such costs and expenses as the Tribunal thinks fit in the circumstances.

58. That health practitioner legislation provide Boards with the legislative power to suspend a practitioner's right of practise or to impose conditions on a practitioner's right of practise pending the outcome of a formal investigation in circumstances where it is in the public interest to do so.

59. That an independent Health Assessment Panel, composed of 1 medical practitioner and a consumer representative be established to receive and determine matters referred by Boards with regards to alleged impaired practitioners.

60. That the Health Assessment Panel have the legislative power to restore a practitioner's right of practise, suspend a practitioner for a specified period pending review, to order a practitioner to undertake specified rehabilitation or other therapy, to impose conditions on a practitioner's right of practise, and to require regular health reviews or other reports to monitor a practitioner's progress.

61. That appeals against a decision of the Health Assessment Panel be to the Professional Review Tribunal and that the composition of the Tribunal for the purpose of hearing an appeal be the Chair, the consumer representative, a member of the practitioner's profession and two other persons who have expertise relevant to the alleged impairment of the practitioner.

62. That proceedings of the Health Assessment Panel and appeals against a decision of the Health Assessment Panel be closed proceedings and that the legislation prohibit disclosure of confidential information.

63. That statutory protection be provided to any person, who in good faith, reports a practitioner or supplies a Board with information about a practitioner who may be incompetent, impaired or guilty of professional misconduct.

64. That formal internal and external evaluation processes be established to ensure that the professional regulatory structures, function and processes continue to meet their public mandate.

65. That the results of the evaluations of regulatory effectiveness be required to be included in the annual report to the Minister.

66. That all restrictions on advertising by health practitioners be repealed and that a penal provision be implemented that make it an offence for any health practitioner to advertise in a false, misleading or deceptive manner.

67. That all provisions relating to restrictions on ownership of health practitioner businesses be removed.

68. That a penal provision be implemented which would make it an offence for a person, company or its employees, agents or directors, to engage in conduct that results in, or is likely to result in, undue influence on a health practitioner employed in the provision of health services to the public by the company.

69. That the revised fee schedule in Chapter 9 be implemented.

70. That the Professional Boards retain the income received by way of fees and that Government provides an annual grant of $400,000.00. This grant would be reviewed three years after the new legislation with the long term view that the Professional Boards be self funding.

71. That any new legislation for the regulation of health practitioners only give statutory protection to recognised titles.

72. That the Health Professions Authority, in conjunction with the Professional Boards, be legislatively required to provide recommendations to the Minister within two years of commencement of the new legislation, or within any longer period that the Minister

determines, on a future model for health care practises regulation utilising a public protection focus.

73. That a dedicated project manager be appointed to implement the accepted recommendations.

74. That if the recommendation to replace the current legislation with omnibus legislation is accepted, the current Nurses Bill not be proceeded with.

BACKGROUND TO THE REVIEW

Context Of The Review

The Review of the Professional Registration Boards was undertaken with the objective of developing an appropriate model for the effective and efficient regulation of Health Professionals in the Northern Territory.

The fast developing global economy, increasingly dominated by trade blocks, the seeming decline of nation-state and the increasing influence of local socio-political groups, are together creating a changeable social context. At the same time, technological advances are profoundly changing how we view our world. As we approach the millenium the forces of technological, socio-political and economic change are creating a dynamic and fluid society.

The rationale for all occupational regulation is the protection of the public interest. While this concept is somewhat amorphous, it is generally understood to imply that the community has a need to be protected from activities which, if undertaken by an inappropriately educated person, may pose a serious potential for harm to the mental or physical wellbeing of the community. This public protection rationale is premised on the belief that regulated professionals deliver safer and higher quality health care and thereby minimise the personal, economic and social consequences of inappropriate and unsafe health care practises.

Statutory licensing of health care practitioners identifies those who possess the qualifications considered necessary for the safe and competent practise of a specific type of health care. Registration Acts prohibit unregistered persons from using particular health practitioner titles and sometimes also prohibit unregistered persons from providing certain types of health care. In this manner, health professional regulation can be seen as forming but one part of a quality system to ensure the protection of users of the health care system.

Contemporary views of professional regulation hold that the public's interest could be best served by ensuring that regulatory frameworks:

- Go beyond initial assessment for registration to ensuring continuing competence of practitioners;

- Promote effective health outcomes and protect the public from harm;

- Are accountable to the public;

- Respect consumer's rights to choose their health care providers from a range of safe options and facilitate consumers to be knowledgeable managers of their own care; and

- Encourage a flexible, rational and cost-effective health care system that allows effective and evolving working relationships among health care providers.

Professional regulatory frameworks therefore need to be developed so as to allow for mechanisms that not only ensure appropriate and effective standards of care, but also individual practitioner competence.

This review has been conducted in the context of several other national and international developments. These include the:

- National Competition Policy reforms, and in particular, the *Intergovernmental Competition Principles Agreement* which requires all Australian governments to undertake reviews of legislation that restrict competition. The guiding principle in this reform area is that legislation should not restrict competition unless it can be demonstrated that the benefits of the restriction outweigh the costs and that the objectives of the legislation can only be achieved by restricting competition.

- The *Final Report of the Review of Professional Indemnity Arrangements for Health Care Professionals*, particularly with regards to the management of complaints processes.

- The final report of the *AHMAC Taskforce on quality in Australian Health Care*, and in particular, Recommendation 34 which states that "A review be undertaken of the role, structure, composition and operation of health professional boards and disciplinary boards with the objective of examining ways to improve the service they provide to consumers and ensuring that their role and methods of operation become well known to the public."

- The Pew Health Professions Commission report on *Reforming Health Care Workforce Regulation.*

- Mutual Recognition Principles.

- National and International approaches to regulation of health practitioners.

Despite the commonality in purpose between the various Boards, there is wide variation in the provisions of the various Acts that underpin them with little rationale for this approach. While it is recognised that there is a need for variation in terms of operationalising some legislative provisions, there is a strong argument for developing a consistent approach to matters that are common to all health professions. Such consistency promotes uniformity in dealing with these matters and is assistive to the public in their understanding of the role and function of Professional Regulatory Boards.

To meet the needs of a changing health care system, health professional regulation needs to be standardised, accountable to the public, flexible to support optimal access to a competent workforce, and effective and efficient in protecting and promoting the public's health, safety and welfare.

Consultation Process

As a result of the breadth of the review and its impact on a broad range of stakeholders, an extensive consultation process was undertaken. In particular, the respective Boards and representatives of the professional groups that are regulated by these Boards have been extensively consulted. Due to the time frame for the review, public consultation occurred only through the public interest members on the current Boards.

In addition to the above face to face interviews, all Boards were surveyed through a questionnaire designed to elicit the strengths and weaknesses of the current model of regulation.

1. REGULATORY PURPOSE AND TERMINOLOGY

The development of regulatory terms has occurred in an adhoc manner, both across the country and within different professional groups. This difference in nomenclature is at best confusing, and at worst creates barriers to the effective utilisation of health professionals.

The difference in terminology can also arguably be shown to be at the basis for some of the criticisms that have been made of professional regulatory authorities in terms of their lack of perceived effectiveness at "protecting the public interest". A clear example of this is the pre-occupation by many professional boards on the registration process rather than the larger governance and policy issues as Boards have identified the registration process as being their key function rather than a process towards achieving the broader outcome. This confusion has been contributed to by the use of regulatory terminology which identified Boards as registration boards. As an example, the term "registration" is generally understood to be a process whereby the particulars of a certain individual, organisation or other are recorded for either administrative, legal or historical purposes. The term does not denote the assurance of standards or in any way imply a protective role. In contrast, the term "regulatory" encompasses direction or control by the use of standards.

A further example of inconsistency in terminology is evident in the varying provisions with the current health practitioner Acts with regards to the making of complaints. *The Health Practitioners and Allied Professional Registration Act 1985* states that "A person may, by notice in writing, lodge with the Registrar a complaint against a practitioner". There is no definition in relation to what matters may constitute a complaint.

In contrast, the *Medical Act 1995*, defines the grounds upon which a complaint may be made against a medical practitioner. The *Dental Act 1986* states that "A person may complain, in writing, to the Board in relation to the professional conduct of a

registered person." No definition is given of the meaning of professional conduct within the context of this Act.

In further contrast, the *Radiographers Act*, the *Optometrists Act*, the *Pharmacy Act* and the *Nursing Act* do not contain any express provision with regards to the making of complaints. Given the importance of these provisions with regards to the protection of the public interest, it is not difficult to understand the concerns voiced by consumers about the adequacy of the protective role of some regulatory Boards.

Adding to the confusion that has emanated from inconsistent terminology, has been the lack of a clearly identified purpose within legislative frameworks. Purposes, where they exist, have been largely function oriented i.e. to register practitioners, approve schools etc. and have not reflected the broader notion of the purpose of the legislation – to protect the public interest.

Given the complexity of current health care practise, it is imperative that not only are regulatory terms consistent, but that legislation developed for this purpose clearly focus its purpose on the public interest mandate.

RECOMMENDATION 1

That any future legislation developed for health professional regulation be consistent in the use and application of terminology.

RECOMMENDATION 2

That the public interest purpose of professional regulatory legislation be clearly defined in any future legislation developed.

2. ENTRY TO PRACTISE REQUIREMENTS

A register of professionals is a document, which informs the public which practitioners have satisfied the requirements to use a registered title. It is an assurance that at the time of his or her initial registration, a practitioner had completed the requirements demanded by the Board and was educated to engage in the activities of the profession. It does not guarantee that the person has, or will continue to, maintain the necessary competence to practise safely.

Despite the variations in professional regulatory legislation, there is an identifiable theme in the requirements for initial registration or entry to practise as a health professional in the Northern Territory. The following table illustrates the current requirements in broad categories.

	Allied Health	***Medical***	***Radiographers***	***Optometrists***	***Pharmacists***	***Dentist***	***Dental Technicians***	***Nurses***
Fit & Proper (includes Good fame & Character)	X	X	X	X	X	X	X	X
Appropriate Qualifications (includes pre-registration clinical training where relevant)	X	X	X	X	X	X	X	X
Medically Fit	X	X				X	X	X
English Proficiency		X						X
Northern Territory Residency		X						

With regards to the above requirements, the criteria of Fit and Proper or Good Fame and Character have been the subject of some criticism in terms of its lack of clear definition. Fit and Proper or Good Fame and Character is not defined in any of the

current health professional Acts. Several individuals consulted during the review commented on the difficulty of applying such generalised provisions to registrants and felt that the provisions of the Acts should be more clearly defined.

Given the consistency that exists it is recommended that there be three broad criteria for registration as a health professional in the Northern Territory – fitness to practise, competence to practise, and completion of an approved course.

Fitness to Practise would include:

- Adequate physical and mental health
- Absence of relevant convictions for indictable offences, statutory offences relating to the professional's practise, and findings of guilt in either civil or disciplinary proceedings in any jurisdiction.
- Absence of relevant current criminal or disciplinary investigations in other jurisdictions.

Competence to Practise would include:

- English proficiency
- Evidence of recent practise as a professional or other evidence of continued competence.

Completion of an approved course would include any pre-registration clinical training required and would be prescribed by regulation. The requirement for completion of an approved course should be nationally consistent in accordance with the Mutual Recognition Principles.

Such criteria can clearly be demonstrated to be in the interest of the public rather than the profession, to be focused on the competence of practitioners, and does not include any criteria which is not based on ensuring the minimum competence required for safe and contemporary practise.

RECOMMENDATON 3

That the requirements for entry to practise as a health professional in the Northern Territory be standardised to three broad criteria; (1)Fitness to Practise, (2) Competence to Practise, and (3) Completion of an approved course.

The current requirement in the Medical Act requiring that applicants for registration be residents of the Northern Territory, or intending to be so, does not appear to have any relation to ensuring safe, competent and contemporary health care practise, nor is it consistent with the Mutual Recognition Principles or National Competition Policy Agreement. Further, the control of the movement of persons into and out of Australia is a responsibility of the Commonwealth Government and is not within the role of a professional regulatory authority.

RECOMMENDATION 4

That there be no criteria of Northern Territory residency, or intention to do so, as a requirement for registration as a Health Professional in the Northern Territory.

Registration Categories

In order to facilitate a consistent approach to registration of practitioners across the professions and to provide for maximum flexibility, it is further recommended that there be three categories of registration:

- Full Registration
- Interim Registration
- Conditional Registration

The category of interim registration would be utilised by the Registrar in situations whereby an applicant appears to meet the criteria for full registration but where for example the next Board meeting is not scheduled for some time.

The category of conditional registration would be defined to include:

- Supervised practise
- Pre-registration training for health care practitioners
- Registration with conditions such as those imposed through disciplinary processes in the Northern Territory or other jurisdictions
- Registration for a specific purpose, such as area of need, for limited periods of time, or for other specific purposes such as research.

RECOMMENDATION 5

That any legislation be constructed so as to allow for three categories of registration – Full Registration, Interim Registration and Conditional Registration.

Area of Need

In relation to registration of medical practitioners (or others), who do not meet the normal requirements for registration but who are registered on the basis that they meet an area of need, it is recommended that the Minister be responsible for determining whether an area of need exists. Requiring the Minister to determine area of need is consistent with the policy responsibility of Government and ensures that the Board's focus is clearly on meeting the need of public protection through satisfying itself that individual practitioners are safe and competent to undertake practise.

RECOMMENDATION 6

That determination of area of need is the responsibility of the Minister assigned responsibility for the Act.

Accreditation of Courses

Consistent with current provisions, those Boards who have responsibility for the accreditation of courses leading to registration should retain this function. In order to facilitate future educational development in the Northern Territory, it is recommended that other Boards be given this power for use when and where it is appropriate.

RECOMMENDATION 7

That legislative provision be included in any new Act to allow the professional boards the power to accredit courses leading to entry to the register.

Registration of Specialties

Consistent with the approach in the majority of jurisdictions in Australia and in line with the National Competition Policy Agreement, entry to the register for health professionals should be limited to the initial qualification for practise i.e. as a medical practitioner, as an optometrist, as a registered nurse or midwife. Specialty regulation should be maintained within the non-statutory regulatory model such as that which exists within the professional colleges. To facilitate consumer knowledge, provision should be made for health practitioners to have their specialist qualifications noted on the register.

RECOMMENDATION 8

Entry to the register should be limited to the initial qualification for practise, however provision should be made for health practitioners to have their specialist qualifications noted on the register.

Regulated Health Care Practitioners

The basis for the regulation of health care practitioners is the issue of the potential for public harm. If there is not a risk of harm to the public then there is no pure legislative reason for regulating the occupational group. On this basis and consistent with current legislation it is recommended that the follow health care practitioners be regulated by statute.

- Aboriginal Health Workers
- Chiropractors
- Dentists
- Medical Practitioners
- Occupational Therapists

- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Psychologists

RECOMMENDATION 9

That a register be maintained for Aboriginal Health Workers, Chiropractors, Dentists, Medical Practitioners, Occupational Therapists, Optometrists, Osteopaths, Pharmacists, Physiotherapists, and Psychologists.

Given the changed nature of health care practise and practitioner education, it is further recommended that a register be established for registered nurses and midwives only. As registered nurse education is now of a generalist nature, excluding midwifery, and as a result of the two Administrative Appeals Tribunal decisions with relation to applications under Mutual Recognition in the Northern Territory and the Australian Capital Territory, there is no longer any basis for the maintenance of registers beyond this level. For those practitioners who have undertaken Specialist education only, such as Mental Health Nurses, these persons can be accommodated in a new regulatory structure by the granting of conditional registration limiting the practitioner to the area of educational preparation. A roll would also need to be maintained for enrolled nurses, with mothercraft nurses being enrolled with conditions.

RECOMMENDATION 10

That a register be established for registered nurses and midwives and that a roll be established for enrolled nurses.

On the basis that Podiatrists are registered in 7 out of 8 jurisdictions in Australia, it is recommended that in line with the Mutual Recognition Principles that a register be established for Podiatrists in the Northern Territory. Given the small number of practitioners that this would involve, it is recommended that a separate Board not be

established and that the Podiatrists be included in a combined Chiropractors, Osteopaths and Podiatrists Board.

RECOMMENDATION 11

That a register for Podiatrists be established in the Northern Territory and that the Podiatrists be included in a combined Board with the Chiropractors and Osteopaths.

Specific Entry to Practise Issues

As a part of the establishment of Mutual Recognition Arrangements, all Australian Governments gave agreement that radiography would remain a regulated profession. Currently, two distinct models for regulation of radiographers occurs throughout Australian jurisdictions. In New South Wales and South Australia, radiographers are regulated through a licensing system established under the Act that regulates radiation safety. A similar system is to be introduced in Queensland in August, 1998.

In Tasmania, Victoria and Northern Territory, regulation of radiographers occurs through registration by a Radiographers Registration Board. Western Australia has adopted legislation that requires persons who operate ionizing radiographic machinery to be accredited by the Australian Institute of Radiographers. The exact mechanism for implementing this, i.e. by licensing or registration, has not yet been determined. The Australian Capital Territory does not regulate the practise of radiography through any mechanism.

The Australian Institute of Radiographers holds the position that the practise of radiographers should be regulated in every jurisdiction. Their preferred model of regulation is that of registration with professional registration boards on the basis that these Boards are better equipped to deal with issues of standards of practise and can deal with not only the requisite qualifications required for practise, but also the issue of fitness to practise.

The Radiographers Board of the Northern Territory is essentially a benign institution. The extent of its functioning has been to (a) approve people for registration as a

radiographer and it does this on the basis that an individual has accreditation from the Australian Institute of Radiographers; and (b) to issue permits for other health care practitioners to undertake radiographic procedures, namely medical practitioners, chiropractors and dentists. Records of the Board reveal that the Board has not, at least in the previous twelve years, dealt with a complaint from a consumer or dealt with any other issue other than the registration of radiographers and issuing of permits. The Board meets infrequently, with the interval between the last Board meeting in May, 1998 and the previous Board meeting being 10 months.

The licensing of radiographic equipment and nuclear technicians is currently undertaken by Northern Territory Health Services through the provisions of the *Radiation Safety Control Act 1978*. Given the lack of effective functioning of the current Radiographer's Board, the regulatory system in operating in three other jurisdictions, and the licensing system currently existing for nuclear technicians, it would be far more effective and efficient to license radiographers under the same legislation.

RECOMMENDATION 12

That the Radiographers Board be disbanded and that the future regulation of Radiographers be incorporated into the provisions of the *Radiation Safety Control Act 1978*.

RECOMMENDATION 13

That pending the amendment of the *Radiation Safety Control Act 1978* to incorporate the above recommendation, and the establishment of a satisfactory process, the *Radiographers Act* not be repealed.

On the basis that dental radiography is a component of the education and usual practise of Dentists, it would appear to be over-regulation to require these persons to have a permit to undertake dental radiography in addition to their license as a dentist. This is particularly so when it is considered that the radiographic equipment being used is already subject to inspection and testing under the permit system under the above Act. It is recommended that the licensing of dental practitioners in any new

legislation include dental radiography, and that a license to practise as a dentist be sufficient regulatory control for the purpose of dentists undertaking the restricted practise of dental radiography. The same provisions should equally apply to Chiropractors.

RECOMMENDATION 14

That Dentists and Chiropractors be exempted from requiring a license pursuant to the *Radiation Safety Control Act 1978*.

RECOMMENDATION 15

That legislation regulating the practise of Dentistry and Chiropractic make provision for these practitioners to undertake limited radiographic procedures and that a license to practise as a Dentist or Chiropractor, as the case may be, be sufficient authority for these practitioners to undertake that practise.

In relation to permits issued to medical practitioners and other health care professionals for the purpose of undertaking limited radiographic procedures in areas where no radiographer is available, it is recommended that these persons be licensed pursuant to the *Radiation Safety Control Act 1978* following the satisfactory completion of the course currently run by Northern Territory Health Services for this purpose.

RECOMMENDATION 16

That the authority for issuing of permits to medical practitioners and other health care practitioners be incorporated into the *Radiation Safety Control Act 1978*.

In addition to the general provision that a person requesting issue of a license to undertake radiographic procedures demonstrate that they have the appropriate education, it is further recommended that there be a requirement in the *Radiation Safety Control Act 1978* that the person also be a fit and proper person. This provision could be based on the definition previously recommended.

RECOMMENDATION 17

That the *Radiation Safety Control Act 1978* require persons applying for a license or permit to operate radiographic equipment to, in addition to possessing appropriate educational qualifications, be a fit and proper person.

With regards to the regulation of ancillary Dental Workers, it is recommended that these persons not be registered as a separate category of health practitioner. It is further recommended that the Dental Board have the legislative power to authorise these and other classes of persons, by regulation, to undertake dental activities which, if undertaken by an inappropriately educated person, may pose a serious potential for harm to the mental or physical wellbeing of the community. This model is consistent with that which exists for Dental Therapists in five Australian jurisdictions, and for Dental Hygienists, in three jurisdictions, and is congruent with the National Competition Policy Principles.

RECOMMENDATION 18

That ancillary Dental Workers, such as Dental Hygienists and Therapists, not be registered as a separate category but that the Dental Board have the legislative power to authorise these and other classes of persons, by regulation, to undertake dental activities which, if undertaken by an inappropriately educated person, may pose a serious potential for harm to the mental or physical wellbeing of the community.

It is further recommended that all Professional Boards have a similar legislative power, through regulation, to grant an authority for other classes of persons to undertake restricted activities, which if undertaken by an inappropriately educated person, may pose a serious potential for harm to the mental or physical wellbeing of the community.

RECOMMENDATION 19

That all Professional Boards, through regulation, have the legislative power to grant an authority for other classes of persons to undertake activities restricted to a professional group where there is a public need and the public's safety can be assured.

3. FUNCTION AND STRUCTURE OF BOARDS

Function

Statutory regulation of professionals gives the force of law to standards that define the proper conduct and practise of particular health practitioners.

Successive inquiries into "professional governance" have recognised that the statutory establishment of a regulatory Board with a membership drawn either entirely or mainly from a particular peer group, is effectively a limited delegation of State power to that peer group to regulate its own. While this delegation is necessary, it is essential that the delegation of power be exercised in the public interest and with maximum accountability to the public. This system differs from what is normally termed "self-regulation" because the membership and functions of a Board are set down in legislation and not determined by the health practitioner group alone.

Concern has also been expressed, that despite the delegation of State power which provides Boards with their authority, some Boards or individual members have expressed the view that the Boards are not exercising a Government function at all because they merely exist to administer their enacting legislation. It is important that statutory Boards do not operate in isolation without regard to their role as part of a broader system of health care regulation, and it is for this reason, that all Boards should be accountability to the Minister for Community and Health Services. Further, such accountability assists to minimise the potential for regulation to create self centered and self protecting groups which may pursue financial and other rewards for the profession instead of pursuing the public interest.

Professional regulatory Boards have traditionally had four broad functions:

- Maintenance of a register which identifies practitioners who have the educational qualifications to be entered on to the register;

- Determination of the educational and other qualifications required for registration;

- Receiving of complaints and the disciplining of practitioners; and

- Prosecution of certain penal provisions relating to illegal use of titles and/or illegal practise of restricted activities.

Traditionally Boards' functions have not been strongly focussed on the development or maintenance of standards of practise save through the disciplinary process. This has on many occasions resulted in Boards reactively "protecting the public interest" with little focus on proactive measures. It is recommended that Boards' functions be broadened to allow them the power to proactively implement measures that would assist in protecting the public interest.

RECOMMENDATION 20

That Board's primary functions be:

- To assess applications for registration and register persons who meet the requirements for registration.
- To maintain a register.
- To ensure that registrants continue to maintain competence and comply with conditions of registration.
- To provide guidance to the profession on clinical, conduct and ethical matters.
- To publish and distribute information pertaining to the Act to the public, the profession and other interested parties.
- To receive complaints about registrants, initiate investigations into complaints and other matters as prescribed in the Act.
- To accredit courses leading to entry to practise.
- To endorse continuing education programs.
- To participate in any national or other body concerned with national policies for the regulation of the profession.
- To advise the Minister on matters related to the profession.

Structure

The current administrative structure of the Professional Boards is that of a secretariat responsible to the Director of Legal Services, Northern Territory Health Services. This structure, while possibly having some efficiencies in terms of resources, lacks any dedicated process for providing direction to the Boards and can be viewed as a factor which limits the Boards' ability to fulfill their statutory mandate.

Administration of the Professional Boards by Northern Territory Health Services may also be seen to pose a conflict of interest. One respondent to the review commented that some health care consumers perceive that to complain to the Professional Boards with regards to a health care practitioner "…is to bite the hand that feeds you". On questioning, this respondent indicated that some consumers perceive the Professional Boards to be Northern Territory Health Services. This perception has apparently emanated from the current administrative arrangements for the Boards and is potentially exacerbated in a small jurisdiction such as the Northern Territory.

In considering any future structure for the administration of the Professional Boards, there are several key issues, which need to be addressed:

- The costs and benefits associated with any model;
- The need to ensure a responsive support service is available to the Boards;
- The context of the Northern Territory;
- The need to ensure public accountability;
- The extent to which the Boards should be independent of Northern Territory Health Services; and
- The level of public funding.

While a range of options may exist including maintenance of the status quo or creating autonomous administrative arrangements for each Board, it is recommended that they most viable option in terms of fiscal efficiency, effectiveness and

accountability is that of a centralised independent authority responsible for the administrative support of all Professional Boards.

In addition to the fiscal efficiencies that such a model brings, a centralised administration can facilitate the co-ordination, consistency and public accountability of the whole Professional regulatory system. Such an authority would be directly responsible to the Parliament through the Minister for Health and Community Services.

RECOMMENDATION 21

That an independent statutory authority called the Health Professions Authority be established to administer the Professional Boards.

To ensure effective public accountability, it is recommended that the Health Professions Authority, and hence the Boards, be subject to normal public accountability processes such as the Ombudsman's Act, and any public sector management standards.

RECOMMENDATION 22

That the Health Professions Authority be subject to normal public accountability processes such as the Ombudsman's Act, and any public sector management standards.

It is further recommended that the Minister's powers in relation to the Health Professions Authority ('the Authority") and the Boards be made explicit in the enacting legislation. These powers should include the power to:

- Require reports and information from the Authority or a Board.
- Notify the Authority or a Board of public sector policies and require them to be followed.
- To make funds available to the Authority or a Board by way of loan or grant and to waive repayment.

- To require the Authority to provide the Minister with an annual report of the Authority's and the Board's activities including financial statements.

RECOMMENDATION 23

That the Minister's powers in relation to the Health Professions Authority and the Professional Boards be made explicit in the enacting legislation and include the power to require reports and information from the Authority or a Board, to notify the Authority or a Board of public sector policies and require them to be followed, to make funds available to the Authority or a Board by way of loan or grant and to waive repayment, and to require the Authority to provide the Minister with an annual report of the Authority's and the Board's activities including financial statements.

Staffing

Registration

Following the establishment of the Health Professions Authority, the Authority would become the employer of the Professional Boards administrative staff in accordance with the provisions of the *Public Sector Employment Management Act 1993*. A Chief Executive Officer, who has a high level demonstrable knowledge of, and experience in, a regulatory environment should be employed to lead the Authority. In addition to managing the Authority, this person would also be responsible for providing leadership and direction to the Boards in terms of understanding and fulfilling their statutory mandate and would be the officer accountable for the Authority. The need to have a person who could provide the Boards with leadership was identified both by the current Boards and their staff. The establishment of such an authority would also provide Government with an additional resource in terms of policy development for regulatory issues.

The Authority would be broadly responsible for:

- The provision of general administrative support to the Boards;
- The maintenance of registers;

- Collection of fees;
- Provision and maintenance of accommodation;
- Legal and legislative advice;
- Investigation of complaints received by Boards; and
- Other functions as delegated by the Boards or legislation.

Given the recommended role for the Authority, a re-structure of the resources available to the Boards would be necessary. During the consultation phase, many respondents identified that a limitation to the Boards' fulfilling their role was a lack of appropriate resources.

Two key areas that were identified by respondents in terms of a lack of resources were research/policy expertise and resources for undertaking investigations. A review of the current staffing structure identifies that the majority of human resources currently go into the registration functions of the Boards. Resources available for policy research is limited where it exists, and Boards clearly identified this as a limitation to them fulfilling their statutory role and to their near exclusive focus on the registering of practitioners.

Three factors significantly lead to this high level resource commitment to the registration process. The first is that of the significant difference in registration requirements of the various Boards, the second is the current processes used for registering, and the third is the process of registration approval.

Currently approximately 1350 new applications for registration occur annually in the Northern Territory. Of these, approximately 90% are via the *Mutual Recognition Act*. Currently each Board has two application forms; one for registration via the Northern Territory Act and the other for applications via Mutual Recognition. Three staff are involved daily in the processing of registrations with another three staff devoting considerable periods of their time in assisting of finalising of these applications.

As a comparative example, the Nurses Board of Victoria process approximately 3000 applications for registration annually. Two administrative staff are employed to

undertake this function. An important factor that aids in the staff of the Nurses Board of Victoria being able to process this number of applications is the consistency in requirements of registrants. Adoption of ***Recommendation 8*** in terms of Entry to Practise requirements would achieve a similar outcome in the Northern Territory and significantly reduce this workload, while allowing for a redirection of resources to the governance functions of the Boards.

With regard to the processes used for registering, streamlining of the processes could occur if a standardisation of the requirements for registration was implemented. Processes such as one application form for registration under the Northern Territory legislation and one application form for applications under Mutual Recognition. Implementation of REGIS (Registration Information Management System) purchased on licence from Technology One, and the cessation of the largely manual process, would also facilitate greater efficiency in this area.

The process for approval of registrations could also be streamlined through Boards, utilising a Governance approach to regulation and adopting policy that delineate the requirements for registration. If such an approach was adopted, the Registrar could automatically register those persons that met the requirements and refer to the Boards those applicants who do not meet the requirements. This would also assist Boards in focussing on the role of governance versus process, and provide for more opportunity for considering broader policy issues.

RECOMMENDATION 24

That following the implementation of REGIS, the current processes for registration be reviewed with the aim of simplifying and streamlining the current administrative process.

RECOMMENDATION 25

That legislative provisions be enacted that allow Boards to delegate the authority to the Registrar for registering persons who comply with the requirements of the Act.

RECOMMENDATION 26

That Boards adopt a governance approach to registering practitioners and develop policy that authorises the Registrar to register those practitioners that meet the delineated requirements of policy.

The current structure provides for 1 senior registrar, 2 registrars, and 3 deputy registrars. While it is acknowledged that the senior registrar and registrars are involved in other aspects of Boards business, a large component of their time is devoted to registration functions. Movement of the renewal date to a single common date for all practitioners, and implementation of ***Recommendations 23, 24 and 25*** would facilitate a reduction in staff specifically devoted to the registration function to two – one registrar and one deputy registrar. This would then provide for the other human resources to be more effectively deployed to assist the Boards in terms of their governance and policy functions and would ensure clear delineation of roles ***(See Recommendation 28).*** During peak periods of operation such as renewal, additional temporary administrative assistance would be used. The Registrar should also be the Information Systems Manager given their unique involvement with the system.

RECOMMENDATION 27

That there be two staff specifically devoted to registrations for all Professional Boards; one registrar and one deputy registrar.

RECOMMENDATION 28

That the annual licence renewal date for all practitioners be moved to a common single date.

Research and Policy

As previously discussed, Boards identified a lack of research and policy expertise as being a significant factor in their limited achievements in terms of professional governance. Currently, research undertaken in terms of policy and governance issues is generally undertaken by Board members where possible. Effective regulation requires adequate resources and support and it is not feasible or realistic to expect part

time members of a Statutory Board to be undertaking the necessary research for policy development.

RECOMMENDATION 29

That three Research/Policy Officers be employed to provide policy development support to the Professional Boards.

Complaints Management

The current processes used by the Professional Boards for the management of complaints that require investigation varies from Board to Board. While all Boards have a similar initial phase of requesting the practitioner to respond to the complaint, the person(s) responsible for further investigation varies from the Chief Medical Officer in the case of the Nurses Board, to legal practitioners in the case of the Medical Board and Board members in the case of other Professional Boards.

The use of the Chief Medical Officer or Board members is beset with the same resource impediments that affect the Boards in terms of policy development. Further the use of Board members is subject to the criticism that the Boards are "judge, jury and executioner". This contradicts the principles of natural justice because the impartiality of the process is prejudiced.

While the use of legal practitioners by the Medical Board removes the above potential criticism, it adds considerably to the expense of managing complaints. Further the variation in processes inhibits the abilities of the Boards to develop a core expertise in the management of complaints.

To remove the potential for prejudicing the complaint process and to facilitate greater fiscal efficiency, it is recommended that a Complaints Officer be appointed. This person would be responsible for investigating all complaints referred to him/her by the Boards and would also ensure accountable management of complaints. This person would also serve as a point of first contact for consumers. The Health and

Community Service Complaints Commissioner has indicated his willingness to facilitate training for this position.

RECOMMENDATION 30

A Complaints Officer be appointed to undertake investigations and manage the Professional Boards complaints process.

RECOMMENDATION 31

That the organisational structure contained in Appendix C be implemented.

Board Membership

The composition of Board membership is the cornerstone of Health Professional Regulation. The structure of many Boards has been the focus of much public criticism about professional self-interest; particularly in cases where membership is exclusively limited to members of the profession being regulated.

> *This is not a new phenomena – George Bernard Shaw lobbied in the 1920's for the General Medical Council (GMC) to have a majority of lay people. His efforts had some impact. The GMC appointed Lord Kennet as the first lay member in 1926.*[1]

To address these criticisms, Governments have moved to add consumer representatives to professional Boards. Currently, the Medical Board, the Chiropractors and Osteopaths Board, and the Psychologists Board have consumer membership albeit that the representation is limited to one member. Legislative provision also currently exists for the Physiotherapy Board and Occupational Therapists Board to have a consumer member. These positions have been unable to be filled and it is therefore imperative in any future model that innovative avenues for consumer recruitment be employed.

[1] Shaw, B., *Doctors Delusions*, Constable and Co., London, 1931, pp.47-48.

The International Council of Nurses (ICN) suggests that:

> *"…members of the public should participate in the regulatory processes to interpret and represent the public needs and wishes and to monitor standards and processes in accordance with those interests…it is not in the best interest of the public for a profession to be unchallenged in its regulatory standards and processes, because the profession may misunderstand or undervalue the public interest it purports to serve."*[2]

While it is important to support consumer participation on Boards, it is equally important to ensure consumer effectiveness on Boards. The effectiveness of consumer members is integral to the effectiveness of Boards regulating in the public interest. For this reason, it is imperative that the process for selecting consumer members does not inhibit consumer appointments and that consumer members be provided with an adequate orientation and resources to support them in their role. The provision of an adequate orientation and resources to support practitioner members of Boards is equally important particularly if members are to be effective in their role. Support for consumers is particularly vital if they are to be an effective partner in the regulatory process and it is for this reason that limiting consumer representation to one member is not recommended.

RECOMMENDATION 32

That all Professional Boards have at least two consumer members included in their membership.

RECOMMENDATION 33

That an adequate orientation and resources be provided to support both consumers and practitioners in their role as members of professional Boards.

In addition to ensuring consumer representation, Board membership should also, as far as is practicable, be representative of the community in terms of gender, social and

[2] International Council of Nurses, *Report on Regulation of Nursing*, ICN, Switzerland, 1986, pp.39

racial background. In order to further avoid the notion that the Boards either represent the profession or Northern Territory Health Services and not the public, it is recommended that all appointments to Professional Boards be made by the Minister for Health and Community Services and not be based on ex-officio appointment.

RECOMMENDATION 34

That all appointments to Professional Boards be made by the Minister for Health and Community Services and not be based on ex-officio appointment.

RECOMMENDATION 35

That in making appointment to Professional Boards, the Minister should have regard to gender, social and racial background.

The size of the Professional Boards' membership should be guided by the nature of the profession, the numbers of registrants and the size of the population of the Northern Territory. Giving regard to the above and on the basis that there should be two consumer members on each Board, it is recommended that the size of Boards vary between five and seven members. On the basis of numbers of registrants, it is recommended that Medical and Nurses Board membership be seven and that the remaining Professional Board membership size be five.

RECOMMENDATION 36

That the size of the membership of the Medical and Nurses Board be seven and that the size of the membership of the remaining Professional Boards be five.

Views were raised during the consultation about the benefits of having other groups represented on Boards such as legal practitioners, ethicists and particular specialist practitioners. While benefit may be gained in having such expertise, it is not recommended that additional membership categories be included in legislation as to do so may result in positions being unable to be filled. In considering the appointment of members, the Minister should give regard to ensuring the broadest possible expertise in Board membership.

RECOMMENDATION 37

The composition of Professional Boards be limited to two consumer representatives and practitioners who hold a current licence to practise in the relevant profession in the Northern Territory. In making appointments, the Minister should give regard to ensuring the broadest possible expertise in the membership.

Given the potential difficulty in recruiting consumer representatives, it is further recommended that a consumer representative be permitted to hold an appointment as a member of more than one Board concurrently.

RECOMMENDATION 38

That a consumer representative be permitted to hold an appointment as a member of more than one Professional Board concurrently.

As the Chair of any Professional Board is the spokesperson for that Board, it is recommended that the Chair be a practitioner and that the Board on the basis of an election held among the members appoints them. In the absence of the appointed Chair, the legislation should provide that the Board may appoint a temporary Chair for the duration of the appointed Chair's absence.

RECOMMENDATION 39

That the Chair of any Professional Board be a practitioner and that they are appointed by the Board on the basis of an election held among the members.

RECOMMENDATION 40

That the legislation provide that the Board may appoint a temporary Chair in the absence of the appointed Chair.

Remuneration of Board Members

There was broad support during the consultation process for Board members to receive tangible acknowledgement of the commitment in both time and resources that they make to Professional Boards. This support was equally acknowledged by both consumer and practitioner members. This support was particularly highlighted by those members who were not public servants and therefore had to go forego potential income to participate on the Board. It is therefore recommended that those members of Professional Boards who are not public servants, be entitled to a stipend of $100.00 per meeting regardless of duration. This payment would be in addition to the reimbursement of travel expenses incurred on Board business.

RECOMMENDATION 41

That members of Professional Boards who are not public servants be entitled to a stipend of $100.00 per meeting, regardless of duration.

4. CONSUMER AND PRACTITIONER INFORMATION

Traditionally, Professional Regulatory Boards have provided little information to consumers about practitioners or their role and purpose. Health care consumers need information about the skills of any health care professional from whom they may seek assistance, what to do if something goes wrong with their health care, and the services and assistance that can help them if they believe their health care provision was inappropriately or incompetently provided.

While Professional Boards do not have the sole responsibility for ensuring consumer knowledge about health care, Boards do hold information such as current licensure, educational background, specialist qualifications and previous disciplinary actions which can assist consumers in making informed choices. Further, the public needs information about the role of regulatory authorities, the benefits of regulation to consumers, how consumers can be involved in the regulatory process, and information about complaints processes. In addition to assisting consumers to make informed choices, disclosure of information to the public by regulatory authorities improves the public perception of authorities and empowers consumers.

Greater involvement by consumers in regulatory processes is a key mechanism to improving consumer knowledge and faith in the regulatory process. It also helps to identify to the public the profession's collective accountability for its practise. It is incumbent on Boards to find creative ways for genuine public involvement in debate on regulatory policy.

RECOMMENDATION 42

That the Professional Boards develop processes for informing consumers about the role and function of Professional Regulatory Boards including the availability and mechanism of the complaints process.

RECOMMENDATION 43

That the Professional Boards develop processes for ensuring consumer involvement in debate on regulatory policy

RECOMMENDATION 44

That provision be made in future legislation to enable Professional Boards to provide consumers with information about practitioners licence status, educational background, and any civil, criminal or disciplinary judgement.

In addition to providing information to consumers, Boards need to take on a more proactive role of informing and educating practitioners. Standards, where they exist, are rarely communicated to practitioners nor is the role and function of professional regulation or the Professional Boards. This lack of information is central to the misconception that many health care practitioners have of Boards; that is that Boards exist to protect the interest of the profession. An informed profession is essential if Boards are to be truly effective in protecting the public interest.

A key measure that would assist the Boards in proactively protecting the public is to utilise the decisions of formal disciplinary processes to positively influence the education and practise of professionals.

RECOMMENDATION 45

That the Professional Boards implement measures to inform practitioners of the role and function of Boards and to provide practitioners with information of Boards' activities including outcomes of formal disciplinary processes.

5. HEALTH PROFESSION DATA COLLECTION

Currently some Professional Boards assist, on behalf of the Northern Territory Government, the Australian Institute of Health and Welfare to collect labourforce data on defined groups of health professionals. Given the importance of this data in assisting in the planning for future health labourforce needs, it is recommended that the Professional Boards continue to undertake this role.

RECOMMENDATION 46

That the Professional Boards continue to assist, on behalf of the Northern Territory Government, the Australian Institute of Health and Welfare to collect labourforce data.

Several stakeholders consulted during the review, identified the particular difficulties that exist within the Northern Territory with regards to meeting health labourforce needs. It was suggested that the Boards could facilitate Government's labourforce planning needs by collecting specific labourforce information from registrants, particularly in terms of registrant's future intentions in terms of practise and professional support needs. It is recommended that consideration be given to utilising the Professional Boards to collect Northern Territory specific data from designated health professional groups to assist Government in labourforce planning. Implementation of ***Recommendation 23*** would provide the legislative authority for Government to request Boards to undertake this role.

RECOMMENDATION 47

That consideration be given to utilising the Professional Boards to collect Northern Territory specific data from designated health professional groups to assist Government in labourforce planning.

6. CONTINUING COMPETENCE

> *"Continuing public protection, however, is not assured solely by initial licensure. The expanding body of health sciences and practise knowledge, changing health care systems and technologies, and transforming scope of practise requires that practitioners continue to learn and improve their knowledge, skills and clinical judgment throughout their professional careers. The credential earned at the beginning of a career may have little direct relationship to the skills used and required in later practise."*[3]

Professional regulation has traditionally focussed on ensuring the attainment of the necessary knowledge and skills prior to initial registration, with little, or no attention being given to the continued competence of practitioners.

Health professionals practise in a health care environment that is characterised by constant and rapid change. Advances in science and technology; restructuring of service delivery; increasing demands on limited fiscal resources, and changing community needs are continuously influencing the practise environment. These changes coupled with increasing consumer awareness, provide an increased impetus for practitioners to continue to develop their knowledge and skills to ensure they safely and effectively meet the public's need.

Current professional regulatory legislation in the Northern Territory does not empower Professional Boards to ensure the continuing competence of practitioners. The Nurses Board, through policy, requires any practitioner who has been out of practise for greater than five years to undertake a re-entry program prior to be re-licensed. While this policy has as its basis the protection of the public, it is arguably open to legal challenge as the Board has no specific legislative power to require this.

[3] Finocchio, L.J. et. al, *Reforming Health Care Workforce Regulation – Policy Considerations for the 21st Century*, San Francisco, 1995, pp.25

The rationale for State licensure of health care practitioners is premised on the basis that there is an information asymmetry between health care providers and consumers and that licensure identifies to the consumer those persons who are competent to undertake that for which they are licensed. The Quality in Australian Health Care Study highlighted failures in technical skills as being a key contributor to adverse events and emphasised the need to ensure that individual practitioners maintained their competence over time.

Introduction of legislative provisions to ensure continuing competence of practitioners is a proactive means by which the public can be assured, as far as is practicable, that those individuals who hold a current licence to practise are competent to do so. Viewed alternatively from a quality management perspective, it is a regulatory process to ensure quality. Legislative provisions would act in harmony with both an individuals responsibility to ensure they do not undertake activities for which they are not competent and an employer's common law duty to ensure that no employee is employed to undertake activities for which they are not competent. These "quality" checks within the broader health care system should operate as a means of ensuring the *protection of the public interest*.

RECOMMENDATION 48

That legislative provisions be implemented that would allow Boards to require practitioners to provide evidence of their continuing competence prior to licensure and re-licensure. In order to ensure that such processes remain contemporaneous, the mechanisms for achieving this should be left for Boards to introduce via policy.

7. COMPLAINTS AND PROFESSIONAL CONDUCT

One of the key responsibilities of Professional Boards is that of investigating complaints about practitioners. Increasingly, Boards are criticised by consumers for their management of this aspect of regulation.

The Quality in Australian Health Care Study highlighted consumer concerns in this area and lead to the recommendation that a review of Professional Boards be undertaken.

Consumer criticisms of Boards in terms of complaint management generally fall into four categories.

1. Inadequate public information about the complaints process.
2. Inadequate information regarding the progress or outcomes of complaints.
3. Reluctance of Boards to pursue allegations of practitioner misconduct or incompetence.
4. Lack of responsiveness in resolving complaints.

A review of the current complaints management processes that exist within the Professional Boards has identified that there exists room for improvement in terms of categories 1, 3 and 4.

In terms of public information about the complaints processes, recommendations in terms of improving this aspect of the Boards' processes has been made in Chapter 4 of this report; specifically ***Recommendation 39***. Generally, the Boards' processes for ensuring that consumers receive adequate information on the progress and outcomes of complaints are effective. To further enhance this aspect of the Boards' processes, it

is recommended that information on the outcomes of complaints received be made public through the publication of information in the Boards' annual reports.

RECOMMENDATION 49

That information in terms of complaints received and outcomes be published in the Boards' annual reports.

In terms of criticisms that Boards may fail to pursue complaints about practitioner conduct or incompetence, a major limiting factor for the Professional Boards in the Northern Territory is the current legislative provisions. Without exception, current legislation provides Boards with an "all or nothing approach" to the management of complaints. There is no provision for Boards to deal with complaints whereby, a practitioner's conduct or competence may not be to the level to meet the common law definition of professional misconduct, but where, if appropriate changes are not made in terms of the practitioner's conduct or competence, harm may be occasioned to the public.

The current approach leaves Boards only with the power to reactively deal with the public's protection and does not allow them to pro-actively deal with practitioners identified as being at high risk for poor performance. Public protection and practitioner performance would be improved if Boards had greater powers in terms of managing complaints received from consumers. It is therefore recommended, that a two level process for the management of complaints be implemented legislatively so as to allow Boards to both deal with practitioners who have been identified as being at high risk for poor performance but whose conduct or competence does not meet the common law definition of professional misconduct, and those practitioners whose conduct or competence may constitute professional misconduct.

Implementation of a two level process would effectively result in a three level process for the management of complaints about health practitioners – the first level would be one of conciliation undertaken by the Health and Community Services Commissioner and level two and three being undertaken by the Professional Boards in situations where conciliation was not appropriate or failed. Adoption of such a system was

supported during consultation with Boards, professional associations and the Health and Community Services Commissioner.

RECOMMENDATION 50

That a two level process for the management of complaints be implemented legislatively so as to allow Boards to both deal with practitioners who have been identified as being at high risk for poor performance but whose conduct or competence does not meet the common law definition of professional misconduct, and those practitioners whose conduct or competence may constitute professional misconduct.

The power of the Board in dealing with practitioners at high risk of poor performance would be limited to the Board being able to caution, reprimand and/or require the practitioner to give a formal undertaking to the Board to do, or refrain from doing, certain actions. This would enable Boards, for example, to require practitioners to undertake further education or supervised practise or to request practitioners to cease a particular practise that was regarded as being unethical or inappropriate. Hearings before the Board would not be represented hearings and would be closed to the public. The rationale for closing these hearings to the public is that research has shown, that confidentiality in alternative dispute resolution processes, increases the likelihood of the practitioner agreeing to be involved, and reduces the time taken to resolve complaints. Practitioners would have the right to refuse to appear before the Board and in these cases the Board would refer the practitioner to the second level process. In cases where the practitioner disagreed with the Board's finding, refused to give an undertaking, or breached an undertaking, the Board would refer the matter to the second level process for determination.

In order to avoid legal challenges on such a process, it would be necessary to legislatively give an extended meaning to the term professional misconduct. Such extended meaning would include a breach of a by-law of the Board, a breach of an undertaking given to the Board, contravention of the Act or a condition subject to which the practitioner may practise, or being fraudulent, dishonest, negligent or incompetent in professional practise. Extending the meaning of professional misconduct to include negligence, would also facilitate Boards protecting the public

by ensuring that those practitioners who were found guilty of negligent practise, addressed the deficits leading to the finding of negligence.

RECOMMENDATION 51

That the term professional misconduct be legislatively given an extended meaning to include a breach of a by-law of the Board, a breach of an undertaking given to the Board, contravention of the Act or a condition subject to which the practitioner may practise, or being fraudulent, dishonest, negligent or incompetent in professional practise.

Evidence gained during the review demonstrated that, in the main, the Professional Boards were responsive in terms of resolving complaints. The only limiting factor in terms of Boards' being responsive was related to a lack of resources. Implementation of ***Recommendation 27*** will further enhance the Boards' responsiveness.

In terms of Boards dealing with practitioners whose practise may constitute professional misconduct, it is recommended that an independent Professional Review Tribunal operating under the mantle of the Health Professions Authority deal with these matters. Establishing the Tribunal independently to the Boards would serve to further ensure that Boards were freed from the criticism of being "judge, jury and executioner" as only the Tribunal would have the power to formally sanction practitioners. The use of one Tribunal for all Boards would also serve to ensure consistency in disciplinary proceedings and would create greater fiscal efficiency. Such a model is also consistent with the principles of natural justice.

The Tribunal would be formed by a legal practitioner of greater than 10 years standing and a consumer representative. In addition to these members, a Board who refers a matter would appoint three of the practitioner's peers, who were not members of the Board, to sit with the two permanent members for the purpose of any hearing. This membership composition facilitates appropriate peer review, conformance with legal formalities, and provides consumer input. Appeals from decisions of the Tribunal, by the Board, a complainant and/or the practitioner, would be to the Supreme Court.

As there is currently no Administrative Appeals Tribunal operating for the Northern Territory, if is further recommended that the Tribunal also be responsible for hearing appeals against a decision of a Board. In hearing an appeal against a decision of the Board, the Tribunal would comprise the Chair and the consumer representative only.

RECOMMENDATION 52

That an independent Professional Review Tribunal, composed of 1 legal practitioner of greater than ten years standing as Chair and a consumer representative be established to hear formal matters referred by a Board against a health practitioner.

RECOMMENDATION 53

That the Professional Board referring a matter of professional misconduct to the Professional Review Tribunal be responsible for appointing three peers to sit with the two permanent members for the purpose of the hearing.

RECOMMENDATION 54

That the Board, a complainant, or a practitioner may appeal against a decision of the Professional Review Tribunal and that these appeals are to the Supreme Court.

RECOMMENDATION 55

That the Professional Review Tribunal also be given the power to hear appeals against any decision of a Board.

A hearing before the Professional Review Tribunal would be of an inquisitorial nature, be a represented hearing, adhere to the principles of natural justice but not be bound by the Rules of Evidence. Hearings before the Tribunal would also be open to the public unless the Tribunal ordered otherwise.

The powers of the Tribunal would need to be broad to ensure that sufficient flexibility existed for the Tribunal to equate the sanction with the severity of the complaint. These powers of sanction would range from a formal caution through to removal from

the register, and would include the ability to impose conditions on practise, to order the practitioner to undertake or refrain from undertaking specified action, suspension of the practitioner's right of practise for a period or to impose a monetary fine. The Tribunal would also have the power to order a practitioner to pay such costs and expenses as the Tribunal thinks fit in the circumstances.

RECOMMENDATION 56

That the Professional Review Tribunal be given broad powers of sanction including, but not limited to, removal from the register, imposition of conditions on practise, order a practitioner to undertake or refrain from undertaking specified action, suspension of a practitioner's right of practise for a period or impose a monetary fine.

RECOMMENDATION 57

That the Professional Review Tribunal be given the power to order a practitioner to pay such costs and expenses as the Tribunal thinks fit in the circumstances.

In order to ensure Boards can act promptly to protect the public in circumstances where, due to the practitioner's competence, conduct or physical or mental ability, the public is at risk, Boards should be given the power to suspend a practitioner's right of practise or to impose conditions on a practitioner's right of practise pending the outcome of an investigation of a complaint. The power to suspend or to impose conditions should be limited to no longer than 1 year and should be subject to appeal to the Tribunal.

RECOMMENDATION 58

That health practitioner legislation provide Boards with the legislative power to suspend a practitioner's right of practise or to impose conditions on a practitioner's right of practise pending the outcome of a formal investigation in circumstances where it is in the public interest to do so.

In dealing with complaints about impaired practitioners, Boards should have the power to ask practitioners to voluntarily undergo a medical, physical, psychological or

psychiatric assessment. In cases where an identified health problem exists, Boards will have the power to accept an undertaking from the practitioner.

In situations whereby a practitioner does not voluntarily agree to undergo a medical, physical, psychological or psychiatric assessment, the Board would refer the practitioner to the Health Assessment Panel. The Board may also suspend or place conditions on the practitioner's right of practise if they believe this necessary in the public's interest and until the matter has been considered by the Health Assessment Panel.

The Health Assessment Panel will consist permanently of a medical practitioner and a consumer representative. The Board will also nominate a member of the practitioner's profession, and any other person considered by the Board to be appropriate in the circumstances. The Health Assessment Panel will be established under the mantle of the Health Professions Authority and will receive referrals from all of the Professional Boards.

RECOMMENDATION 59

That an independent Health Assessment Panel, composed of 1 medical practitioner and a consumer representative be established to receive and determine matters referred by Boards with regards to alleged impaired practitioners.

It is further recommended that the Health Assessment Panel have the legislative power to restore a practitioner's right of practise or to suspend a practitioner for a specified period pending review, to order a practitioner to undertake specified rehabilitation or other therapy, to impose conditions on a practitioner's right of practise, and to require regular health reviews or other reports to monitor a practitioner's progress.

RECOMMENDATION 60

That the Health Assessment Panel have the legislative power to restore a practitioner's right of practise, suspend a practitioner for a specified period pending review, to order a practitioner to undertake specified rehabilitation or other therapy, to impose conditions on a practitioner's right of practise, and to require regular health reviews or other reports to monitor a practitioner's progress.

Both the practitioner and the relevant Board could appeal a decision of the Health Assessment Panel. Appeals against a decision of the Health Assessment Panel would be to the Professional Review Tribunal. The composition of the Tribunal for the purpose of hearing an appeal against a decision of the Health Assessment Panel would consist of the Chair, the consumer representative, a member of the practitioner's profession and two other persons who have expertise relevant to the alleged impairment of the practitioner. The member of the practitioner's profession and the two other persons who had expertise relevant to the alleged impairment of the practitioner would be appointed to the Tribunal by the relevant Board and would not be members of that Board.

RECOMMENDATION 61

That appeals against a decision of the Health Assessment Panel be to the Professional Review Tribunal and that the composition of the Tribunal for the purpose of hearing an appeal be the Chair, the consumer representative, a member of the practitioner's profession and two other persons who have expertise relevant to the alleged impairment of the practitioner.

In order to preserve the confidentiality of health information about a practitioner disclosed to the Health Assessment Panel, it is recommended that proceedings of the Health Assessment Panel or an appeal against a decision of the Health Assessment Panel be closed proceedings and that the legislation prohibit disclosure of confidential information.

RECOMMENDATION 62

That proceedings of the Health Assessment Panel and appeals against a decision of the Health Assessment Panel be closed proceedings and that the legislation prohibit disclosure of confidential information.

Experience in other jurisdictions has shown that many practitioners, and other persons, are reluctant to report practitioners to Boards for fear of civil litigation if the matter is not found proved. In order to remove this fear and to ensure that Boards are able to effectively undertake their role of public protection, it is recommended that statutory protection be provided to persons who, in good faith, report a practitioner or supply a Board with information about a practitioner who may be incompetent, impaired or guilty of professional misconduct. Such a provision should not provide protection for any person who malevolently or vexatiously reports a person or provides information to a Board

RECOMMENDATION 63

That statutory protection be provided to any person, who in good faith, reports a practitioner or supplies a Board with information about a practitioner who may be incompetent, impaired or guilty of professional misconduct.

8. EVALUATING REGULATORY EFFECTIVENESS

Currently, there exists no process for the evaluating the effectiveness of professional regulatory structures, functions or processes.

In order to ensure that professional regulatory structures, functions and processes continue to meet their public mandate, it is recommended that formal evaluation processes be established. These evaluation processes should be both internal to the Boards and external.

RECOMMENDATION 64

That formal internal and external evaluation processes be established to ensure that the professional regulatory structures, function and processes continue to meet their public mandate.

Internal Evaluation

All Boards should undertake internal evaluation of the functioning of the Board as an entity. This evaluation should include, but not be limited to, review of the following factors:

- The extent to which the decisions made by the Board are consistent with their legislative mandate.
- The extent to which the Board's activities have contributed to the Board achieving their legislative mandate.
- The extent to which the level of regulation imposed by the Board is appropriate to ensure the protection of the public and whether less stringent regulation could have achieved the same objective.

External Evaluation

In addition to internal evaluation, the Health Professions Authority should undertake, in conjunction with the Professional Boards, an external evaluation of the regulatory structures, functions and processes. This evaluation should include such things as registration processes, complaint management, and the extent of public input encouraged by the Boards in their decision making processes. The results of these evaluations should be required to be contained in the annual report to the Minister. This inclusion would assist the Boards in demonstrating public accountability and would provide Government with an assurance that the legislative mandate given to the Boards by the legislature was being achieved.

RECOMMENDATION 65

That the results of the evaluations of regulatory effectiveness be required to be included in the annual report to the Minister.

9. BUSINESS AND COMMERCIAL ISSUES

Advertising by Health Practitioners

The current legislation regulating Medical Practitioners, Pharmacists, Dentists and Nurses place varying controls on advertising by their respective practitioners. Whilst the degree of control varies from Act to Act, these provisions essentially place controls on:

- The type, size, style and content of advertisements.
- The frequency with which such advertisements may be made.

The effect of some of these provisions is that health practitioners are restricted from conducting their practises in a commercial manner and from providing information to consumers. A further effect of these provisions is that some Boards have been required to devote inordinate amounts of time and resources to implement and monitor these provisions.

Consumers and other parties, currently have the right to refer complaints with regards to advertising to the Office of Consumer Affairs. As an independent agent, the Office of Consumer Affairs can determine to prosecute advertising offences under the *Consumer Affairs and Fair Trading Act 1990*. Substantial penalties apply under the provisions of this Act for making false or misleading statements in relation to the supply of goods and services. Given the consumer protection that is available through this avenue, it is recommended that all advertising restrictions currently in place be removed, and that the legislation contain a penal provision only making it an offence for any health practitioner to advertise in a false, misleading or deceptive manner. Adopting this approach to advertising for health practitioners allows for normal commercial practises to occur while providing protection for the public in making it an offence for a practitioner to advertise in a manner that could lead to harm.

RECOMMENDATION 66

That all restrictions on advertising by health practitioners be repealed and that a penal provision be implemented that make it an offence for any health practitioner to advertise in a false, misleading or deceptive manner.

Ownership Restrictions

The *Optometrists Act 1980*, the *Medical Act 1995*, the *Pharmacy Act 1980* and the *Dental Act 1986* currently contain provisions with regards to the ownership of health practitioner businesses.

The long standing argument for legislation to contain these provisions has been related to protecting the public from unethical practises of non-health practitioners if such persons were allowed to own health practitioner businesses. Evidence has shown that such protection is illusory in that unethical and fraudulent behaviour occurs in health practitioner businesses that are owned by health practitioners. The level of prosecution of medical practitioners for medifraud is a clear example of this.

Opponents of these current restrictions on ownership argue that they deny the professions and the public the benefits that accrue from alternative business structures such as access to wider sources for investment, reduced costs to professionals and the public through greater competition, and increased efficiencies through innovation and simply shield professionals from exposure to competition. Such views were highlighted in the Independent Committee of Inquiry into National Competition Policy and concluded that the current restrictions are anti-competitive and contribute to higher costs for some services.

Current legislation such as *Corporations Law* control the conduct of businesses within the Australian context. Penalties applying under *Corporations Law* are significant and it is recommended that sufficient public protection is given in this context. On this basis it is recommended that all provisions relating to the restrictions on ownership of health practitioner businesses be removed.

RECOMMENDATION 67

That all provisions relating to restrictions on ownership of health practitioner businesses be removed.

One of the greatest concerns held by some health practitioners is that should ownership of health practitioner businesses be de-regulated then health practitioners may be forced to engage in unethical conduct as a result of the policies of companies. In order to ensure that health practitioners are not unduly influenced to engage in unethical conduct, it is recommended that a penal provision be included which would make it an offence for a company or its employees, agents or directors, to engage in conduct that results in, or is likely to result in, undue influence on a health practitioner employed in the provision of health services to the public by the company.

RECOMMENDATION 68

That a penal provision be implemented which would make it an offence for a person, company or its employees, agents or directors, to engage in conduct that results in, or is likely to result in, undue influence on a health practitioner employed in the provision of health services to the public by the company.

Regulatory Funding

Expenditure

The present funding arrangements for the Professional Boards is via Northern Territory Health Services budget. The budgetary allocation for 1997/98 fiscal year was $472,000.00. This amount represented $326,000.00 for personnel costs and $146,000.00 for operational costs. These figures do not however represent the true cost of administering the Professional Boards as services provided by THS, such as telephone, premises, postage, legal services, salary on costs such as superannuation, workers compensation, Long Service Leave and insurance are not costed to the Professional Boards. These and other hidden costs obscure the true cost of administering the Professional Boards. It is estimated that true cost to Government of

administering the Professional Boards is approximately $665,000.00 and is based on the following figures.

ITEM	*BUDGET ALLOCATION*	*ESTIMATED COST*
Personnel Costs	$326,000.00	$430,000.00 (includes 32% for on costs of LSL, Workers Comp, Super and AL replacement)
Operational Costs	$146,000.00	$235,000.00 (includes estimates for telephone, postage, insurance, and accounting fees. Does not include legal fees and rental or other assistance.)

The estimated cost of the proposed organisational structure in Appendix C is $630,000.00 per annum including 32% for on costs. This cost coupled with an estimated $300,000.00 for operational costs, including telephone, postage, insurance and accounting fees, but excluding legal fees and rental would bring the total estimated cost of operating the Professional Boards in the recommended mode to $930,000.00 per annum. This amount represents an estimated 40% increase in expenditure or $270,000.00 per annum. This amount however must be considered against the estimated $341,000.00 currently contributed by Government through THS. If the recommended fee schedule below is implemented, this amount would represent an increase of approximately 18% or $59,000.00 per annum over the current estimated Government contributions. This model still provides for Government to provide legal services and accommodation for the Professional Boards as is currently the situation

Income

Income received by the Professional Boards, totaling approximately $324,000.00 in the 1997/98 fiscal year is returned directly to Consolidated Revenue and is not used in a direct sense to offset the cost of administering the Boards.

Based on increasing registration and licensing fees to national average, it is estimated that the projected income for the Professional Boards would be $530,000.00. This amount is made up of an estimated $460,000.00 in annual licensing fees and $70,000.00 in registration and other fees. These figures are based on the following fee structure and number of registrants; and on approximately 1100 new nurse registrations, 300 medical and dental registrations, and 70 allied health registrations annually.

PRACTITIONER AND NO'S.	*REGISTRATION FEE*	*ANNUAL LICENCE FEE*	*RESTORATION FEE*	*GOOD STAND CERTS.*	*DUPLICATE CERTS.*
A.H.W.- 400	$25.00	$10.00	$25.00	N/A	$20.00
Chiropractors & Osteopaths – 30	$150.00	$150.00	$70.00	$20.00	$20.00
Dentists (incl. Dental Specialists) –127	$80.00	$100.00	$130.00	$20.00	$20.00
Medical – 1060	$150.00	$150.00	$150.00	$20.00	$20.00
Nurses – 3000	$50.00	$80.00	$20.00	$20.00	$20.00
O.T.'s – 69	$50.00	$100.00	$50.00	$20.00	$20.00
Optometrists – 50	$100.00	$110.00	$100.00	$20.00	$20.00
Pharmacists– 150	$100.00	$100.00	$100.00	$20.00	$20.00
Physio – 90	$50.00	$100.00	$50.00	$20.00	$20.00
Podiatrists – 2	$50.00	$100.00	$50.00	$20.00	$20.00
Psychologists–70	$50.00	$100.00	$50.00	$20.00	$20.00

RECOMMENDATION 69

That the above fee schedule be implemented.

Should Government Contribute?

In most jurisdictions of Australia, save the Australian Capital Territory, professional regulation is predominantly self funding. This is achieved through income generated by the number of practitioners that practise in the jurisdiction. The size, demographics, and locale of the Northern Territory militates against a self funding regulatory system operating in the short term although this should, in principle, be the long term aim.

As previously discussed, the complexity of managing regulatory functions, including the issue of ensuring ongoing competence of practitioners, investigations of complaints and disciplinary actions, managing impaired practitioners, and meeting increased community expectations, requires Boards to be responsive, proactive and innovative in developing approaches to ensuring safe practise. A separate authority will enshrine the Boards' accountability for these matters and give them the necessary autonomy to perform their functions under the legislation while maintaining full public accountability through the Minister. As an independent authority, the hidden costs currently existing within the THS infrastructure will cease and a true cost will be established.

In considering the cost associated with professional regulation, it is important to consider the cost benefits that flow from effective regulation. Incompetent and unethical health care practitioners have the potential to incur inordinate costs to the community, both in terms of fiscal resources and in terms of social and emotional costs. Regulation, similarly to preventive health care, has a primarily prospective benefit in that effectively implemented, it can reduce the overall cost to society for health care provision.

The regulation of Aboriginal Health Workers also creates a uniqueness to the professional regulatory structure in the Northern Territory. The continued need for

the Board to assist in the development of these workers is paramount, and due to the embryonic stage of development of this professional group, there is a need for Government to provide support.

ESTIMATED COST	*ESTIMATED INCOME*	*ESTIMATED GOVERNMENT CONTRIBUTION*
Current Model = $665,000*	Current Fees = $324,000	$341,000.00*
Proposed Model = $930,000*	Proposed Fees = $530,000	$400,000.00*

**Excludes legal fees and rental costs*

Given the circumstances of the Northern Territory, it is recommended that all fees received by the Boards be retained by the Boards and that the Government provides an annual grant of $400,000.00 to the Professional Boards. The level of this grant would be reviewed 3 years after the commencement of the new legislation with the long term view that the Professional Boards be self funding.

RECOMMENDATION 70

That the Professional Boards retain the income received by way of fees and that Government provides an annual grant of $400,000.00. This grant would be reviewed three years after the new legislation with the long term view that the Professional Boards be self funding.

10. A MODEL FOR THE FUTURE

Traditionally regulation has relied on a model of restricting health care practises, through the inclusion of statutory definitions of practise, to registrants and thereby prohibit non-registrants from undertaking these activities. Drafting workable definitions for the purposes of restricting potentially harmful health care practises to appropriately qualified professionals has been fraught with problems however and has resulted in a shift towards "title protection" legislation.

Two significant problems that often occur with the use of statutory definitions is that these definitions often overlap with the legitimate scope of other professionals and can result in "territorial clashes" between professions, and that they often inappropriately restrict activities to certain groups of professionals when other professionals may also possess the competence to safely perform these activities. This unnecessary restriction reduces consumer choice in selecting a health service provider and also arguably adds to the cost of health care.

A further problem that exists with this model is the difficulty in enforcing such legislation when one professional group may legitimately claim competence to perform the activity. Examples of this occur with nursing, podiatry and physiotherapy, nursing and medicine, and physiotherapy, chiropractic and osteopathy where there is a degree of overlap between the professions. Further, as the professions evolve and develop, these restrictions can inhibit the creation of new and innovative models of service delivery.

Where practises are restricted by legislation, there are often exemptions for medical practitioners and other professionals. The fairness and effectiveness of this approach has been widely criticised in that there is no onus on the exempted practitioners to demonstrate competence in the restricted practise. Further, such restrictions are prima facie anti-competitive, and unless they can be shown to be absolutely necessary for the public's protection, it is arguable that they serve only to protect the interests of the relevant professions.

In Ontario, Canada a new regulatory scheme was introduced in 1993. The purpose of this new regulatory scheme was developed to:

- Increase the openness and responsiveness of the health care system.
- Provide a regulatory system that allows consumers greater freedom to choose their health care provider.
- Provide a more flexible regulatory scheme, with elements of consistency for each profession.

This legislative approach regulates only those health care practises that are potentially harmful to consumers and allows for non-regulated health care providers to provide health care that is not deemed to be potentially harmful. This legislation only restricts the use of titles to registered practitioners, rather than attempting to regulate the entire scope of a profession's practise such as occurs in statutory definitions.

This approach recognises that health service delivery occurs in a rapidly changing and developing society and that, in concert with society, professions also evolve, treatment modalities change, and new professions emerge. It is imperative that any new legislation not just meet the challenges of now but be flexible enough to accommodate the changes that will occur in the new millenium.

Given the evolving context of health care provision and the limitations of the statutory definition model of regulation, it is recommended that only title protection be given to professionals in any new legislation.

RECOMMENDATION 71

That any new legislation for the regulation of health practitioners only give statutory protection to recognised titles.

It is further recommended that the Health Professions Authority, in conjunction with the Professional Boards, be legislatively required to provide recommendations to the Minister within two years of commencement of the new legislation, or within any

longer period that the Minister determines, on a future model for health care practises regulation utilising a public protection focus. This recommendation could be implemented in new legislation in the same manner as Section 104 of *the Health and Community Services Complaints Act 1998* legislatively requires the Commissioner to develop a draft Code of Health and Community Rights and Responsibilities. In developing recommendations for the Minster, the Authority and the Professional Boards must invite submissions and consult widely with all stakeholders including consumers.

RECOMMENDATION 72

That the Health Professions Authority, in conjunction with the Professional Boards, be legislatively required to provide recommendations to the Minister within two years of commencement of the new legislation, or within any longer period that the Minister determines, on a future model for health care practises regulation utilising a public protection focus.

11. IMPLEMENTATION ISSUES

The primary implementation issue, regardless of the recommendations accepted, will be that of resources.

Development of new legislation including consultation with stakeholders, will require the dedicated resources of a project manager if successful implementation is to occur. This person would be responsible for the development of an implementation plan, including consultation process and negotiation with stakeholders, and would facilitate the necessary change and development that would need to occur within the Professional Board secretariat.

This person may exist within Territory Health Services or may need to be resourced external to the Service. If the establishment of an independent authority is accepted, consideration may wish to be given to appointing the Chief Executive Officer of the Authority with their initial brief being the implementation of the recommendations of the review.

RECOMMENDATION 73

That a dedicated project manager be appointed to implement the accepted recommendations.

A further issue that requires consideration is that of the current Nurses Bill. If the recommendation for omnibus legislation is not accepted or there is an anticipated lengthy delay, consideration should be given to progressing the Bill. If the recommendations are accepted then it is recommended that the Nurses Bill not be proceeded with and that all current legislation be repealed with the passage of the omnibus legislation.

RECOMMENDATION 74

That if the recommendation to replace the current legislation with omnibus legislation is accepted, the current Nurses Bill not be proceeded with.

APPENDIX A
INDIVIDUALS AND GROUPS CONSULTED

Bob Whitehead	Director Legal Services, Territory Health Services (THS)
Janette Steele	Registrar, Professional Boards
Annie Kovacs	Deputy Registrar, Professional Boards
Julie Burrows	Deputy Registrar, Professional Boards
Lorraine Rankine	Deputy Registrar, Professional Boards
Lynus Gomez	Registrar, Professional Boards
Bernadette McKirdy	Senior Registrar, Professional Boards
Margaret-Ann Cook	Principal Consultant Nursing, THS & Chairperson, Nurses Board
Ken Simpson	Asst. Secretary Corporate Services, THS
Dr Bruce Simmons	Member, Dental Board
Dr Brian Beatty	Member, Dental Board
Dr Mario Carusi	Member, Dental Board
Dr Mark Leedham	Member, Dental Board
Margo Webster	Member, Physiotherapist Board
Lyndall Finch	Member, Physiotherapist Board
John Montz	Chair, Psychologists Board
Harry Krebs	Chair, Occupational Therapists Board
Chris Spargo	Member, Occupational Therapists Board
Ted Hobson	Chair, Chiropractors & Osteopath Board
Terena Saunders	Member, Occupational Therapists Board President, NT Branch, Australian Association of Occupational Therapists
Betty Clarke	Australian College of Midwives Inc.
David Farquhar	Lawyer, Cridlands
Sally Sievers	Lawyer, Cridlands
George Fyson	A/Chair, Pharmacist Board
Lance Chin Quan	Member, Optometrists Board

Alison Martens	Public Interest Member, Psychologists Board
Vic Rowe	D.O.N., Mental Health Service, THS
Peter Panquee	Consultant Aboriginal Health Worker, THS
Dr Dayalan Devanesen	Chair, AHW Board
Adam Lowe	Chair, Physiotherapist Board
Jennifer Woodhouse	Member, Physiotherapist Board
Shelley Forester	Member, Pharmacist Board
Robyn Cahill	Executive Director, NT Branch Australian Medical Association (AMA)
Dr David Meadows	President, NT Branch A.M.A.
Stephen Taaffe	Department of the Chief Minister
Rachael Shanahan	Department of the Chief Minister
Gareth Price	Treasury
Bryan Elliott	Attorney Generals Department
Tom Hurley	Parliamentary Counsel
Peter Boyce	Commissioner, Health & Community Services Complaints Commission
Vic Feldman	Deputy Commissioner, Health & Community Services Complains Commission
Dr Shirley Hendy	Chief Health Officer, THS
Chris Babington	Office of the Commissioner for Public Employment
Dr David Cox	Chair, Medical Board
Dr Charles Butcher	Member, Medical Board
Dr Charles Kilburn	Member, Medical Board
Dr Len Notaras	Member, Medical Board
Steven Thompson	Public Interest Member, Medical Board
John Haynes	Secretary, Australian Nursing Federation
Brad Cassels	Senior Policy Officer, Radiation Health, THS

Margaret Seccafien	Executive Director, NT Branch, Australian Physiotherapist Association
Patrick Maher	President, NT Branch, Australian Physiotherapist Association
Ernie Hughes	General Secretary, Australian Institute of Radiographers
Karen Weston	Senior Business Analyst, THS
Neil Spencer	President, NT Branch, Australian & New Zealand College of Mental Health Nurses.
Dr Jeff Swann	NT Branch, Australian Dental Association (ADA)
Dr Erna Melton	NT Branch, ADA
Dr Owen Hayles	NT Branch, ADA
Yve Weinberg	Public Interest Member, Chiropractors & Osteopaths Board
Sandy Smiles	Member, Nurses Board
Ged Williams	Member, Nurses Board
Jan Gibbett	Member, Nurses Board
Angela Wallace	Member, Nurses Board
Carolyn Wilson	Member, Nurses Board
Professor Jennifer Watson	Member, Nurses Board
Phil Walcott	Member, Psychologists Board
Doug McGufficke	NT Branch, Australian Psychological Society
Professor Kay Roberts	Chairperson, NT Chapter, Royal College of Nursing, Australia.
Bev Turnbull	Senior Lecturer, School of Nursing, NT University

APPENDIX B

OUTLINE OF RECOMMENDED LEGISLATION

PART 1 – PRELIMINARY

1. Short Title – Health Professions Act.
2. Commencement.
3. Interpretation.

Board or Boards means any Board established pursuant to Section 15 of the Act.

Registration includes enrolment, any reference to register includes roll, and any reference to registered includes enrolled.

By-laws means any by-law pursuant to Section 22 of the Act.

Foreign jurisdiction means a legal jurisdiction outside of the Northern Territory.

Health care practitioner means any practitioner registered (or enrolled) pursuant to this Act.

PART 2 – HEALTH PROFESSIONS AUTHORITY

4. Establishment of the Health Professions Authority.
5. Functions of the Authority – includes prosecuting offences against the Act, investigating complaints referred to it by the Boards, establishing and conducting the Health Assessment Panel and Professional Review Tribunal, advising the Minister on developments in statutory regulation and on the needs of the Territory in relation to these matters, and to advise the Minister on other matters relating to this Act.
6. Powers of the Authority.
7. Objectives of the Authority.
8. Relations with the Minister – include the power of the Minister to require reports and information from the Authority or a Board, to notify the Authority or a Board of public sector policies and require them to be followed, to make funds available to the Authority or a Board by way of a loan or grant and to waive repayment, and to require the Authority to provide the Minister with an

annual report of the Authority's and the Boards' activities including financial statements.

9. Delegation.
10. Committees.
11. Establishment and constitution of Professional Review Tribunal
12. Function of Tribunal
13. Actions by Tribunal
14. Costs and expenses of inquiries.
15. Notice of Decisions
16. Appointment of inspectors.
17. Power of inspectors.
18. Specific investigative powers.
19. Establishment and constitution of Health Assessment Panel
20. Function of Health Assessment Panel
21. Actions of Panel
22. Notice of Decisions.
23. Chief Executive Officer and other staff.
24. Use by the Authority of services of persons.
25. Protection from Liability
26. Annual Report
27. Prescribed Fees

PART 3 – ESTABLISHMENT OF BOARDS

28. Establishment of Boards
29. Composition of Boards
30. Period of Appointment
31. Functions of the Boards
32. Powers of the Boards
33. Delegation
34. Committees
35. By-laws

PART 4 – REGISTRATION

36. Application for registration.
37. Requirements of application for registration.
38. Entitlement to registration.
39. Full registration.
40. Interim Registration.
41. Conditional Registration.
42. Cancellation of interim registration.
43. Assessment of entitlement.
44. Recommendation of committee of assessors.
45. Determination of application.
46. Special grounds for refusing registration – lacks fitness to practise, competence to practise, and applicant's entitlement to practise has been cancelled or suspended in a foreign jurisdiction.
47. Review of registration conditions.
48. Restricted practise areas – Boards may by regulation prescribe areas of practise that require special authorisation.
49. Requirements of application for authorisation.
50. Entitlement to Authorisation.
51. Assessment and determination of application for authorisation.
52. Interim Authorisation.
53. Cancellation of authorisation.
54. Registered person to be issued with certificate.
55. Certificates of registration.
56. Annual licence certificates.
57. Replacement and amendment of certificates.
58. Offences in relation to certificates.
59. Register
60. Correction of register.
61. Notice of change of name or address.
62. Inspection of register.
63. Publication of register.
64. Protection of private information.

65. Annual licence fees.
66. Removal from the register.
67. Persons taken off register to surrender certificate.
68. Restoring name to register.
69. Evidentiary provisions.

PART 5 – COMPLAINTS

70. Making complaints – any person who is aggrieved by the conduct or competence of a health care practitioner may make a complaint. The Board on its own motion may also make a complaint.
71. Specific matters in respect of which complaints may be made; includes extended meaning to professional misconduct to include contravention of the Act, contravention of a foreign health care practitioner Act, contravening a by-law, contravening a condition subject to which they are registered, practising without an annual licence, practising in a restricted area without authorisation, contravening a condition of an authorisation, failing to pay a fine, failing to comply with an undertaking given to the Board or the Tribunal, is negligent or incompetent in practise, or behaves in a fraudulent or dishonest manner in practise.
72. Complaints procedure.
73. Preliminary investigation of complaints – Boards may refer matter to the Health Professions Authority for investigation. Authority to supply report of investigation to Board and practitioner who is the subject of the complaint.
74. Referral of complaints – to Tribunal or Health Assessment Panel.
75. Certain complaints to be dismissed.
76. Procedure for less serious complaints.
77. Suspension or imposition of conditions on right of practise or authorisation.
78. Revocation of suspension or conditions.
79. Right of appeal.
80. Hearing of appeals.

PART 6 – OFFENCES

81. Offence to practise if unregistered or not the holder of a current annual licence.
82. False claims.
83. Unauthorised use of titles.
84. Advertising offence – offence for any health care practitioner to advertise in a false, misleading or deceptive manner.
85. Failure to notify Board of civil claims.
86. Failure to notify Board of convictions.
87. Offences of dishonesty.
88. Dishonest conduct – offence for a person, a company or its employees, agents or directors to engage in conduct that results in, or is likely to result in, undue influence of a health practitioner employed in the provision of health services to the public by the company.
89. Obstruction.
90. Offences relating to assessments and inquiries etc.
91. Failure to comply with orders.

PART 7 – MISCELLANEOUS

92. Medical practitioners' notice relating to fitness to practise.
93. Provision of information by bodies corporate.
94. Employer notices of misconduct or incompetence.
95. Service of documents.
96. Presumptions.
97. Evidence of facts found in other proceedings.
98. Fees, penalties and fines to be paid to Board.
99. No right of recovery by unregistered person.
100. Punishment of conduct constituting an offence.
101. Offences by Bodies Corporate.
102. Act does not prohibit certain practises including a person from rendering assistance in an emergency, a person providing care to another person or using lawful tradition or cultural practises in caring for another person, a person who

is registered in a foreign jurisdiction from assisting in the lawful retrieval of organs or tissues for transplanting, or from retrieving or escorting a patient to or from the Territory, or from assisting in similar emergencies or special circumstances, a student in an approved health care practitioner course under supervision and in accordance with and for the purposes of the course.

103. Health Care Practises regulation – the Health Professions Authority, in conjunction with the Boards, must within 2 years after the commencement of this Act or within any longer period that the Minister determines, provide recommendations to the Minister on a future model for health care practises regulation utilising a public protection focus.
104. Regulations
105. Repeal.
106. Savings and Transitional

Schedule 1

Provisions with respect to Membership of Boards

Schedule 2

Provisions with respect to meetings of Boards

Schedule 3

Powers and procedures of Committees of Assessors, Health Assessment Panel and Tribunal – practitioner who is the subject of the inquiry, the complainant and the Authority may have legal representation at Tribunal hearing.

Schedule 4

Provisions with respect to membership of Health Assessment Panel and Tribunal.

Schedule 5

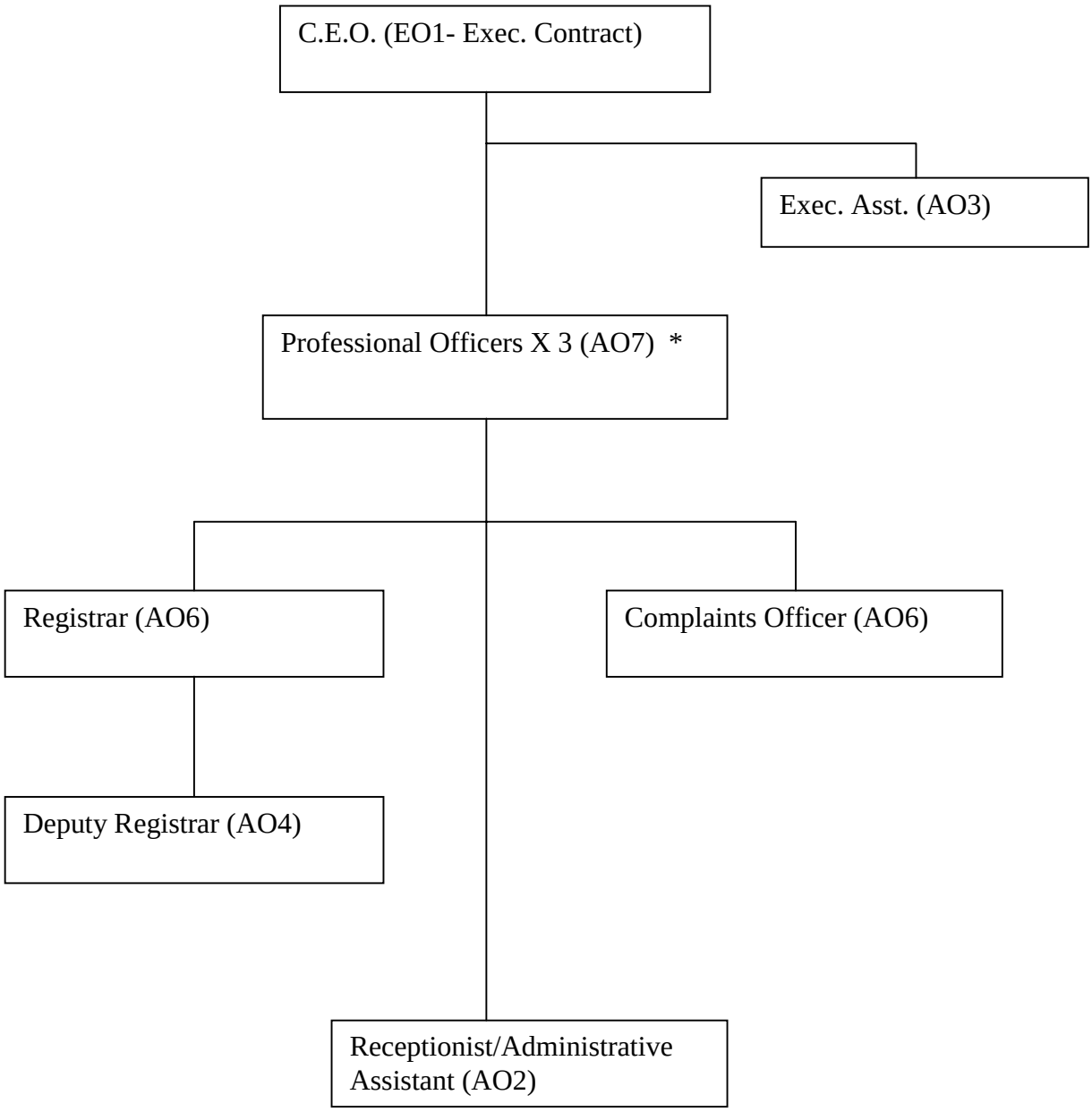
Provisions with respect to proceedings of Tribunal.

Schedule 6

Savings and Transitional provisions.

APPENDIX C

PROPOSED ORGANISATIONAL STRUCTURE



*Professional Officers provide research and policy support to Boards in addition to secretarial role. Officers notionally allocated as follows:

- Nursing & Pharmacy Boards
- Medical & Dental Boards
- Allied Health Boards

APPENDIX D
BIBLIOGRAPHY

AUSTRALIAN HEALTH MINISTERS' ADVISORY COUNCIL, (1996) *The Final Report of the Taskforce on Quality in Australian Health Care.* AGPS, Canberra.

BOHNEN, LS., (1994) *Regulated Health Professions Act. A Practical Approach*. Canada Law Book, Ontario, Canada.

COMMONWEALTH DEPARTMENT OF HUMAN SERVICES & HEALTH, (1995) *Compensation and Professional Indemnity in Health Care. A Final Report.* AGPS, Canberra.

FINOCCHIO, LJ; DOWER, CM; Mc MAHON, T; GRAGNOLA, CM & THE TASKFORCE ON HEALTH CARE WORKFORCE REGULATION, (1995) *Reforming Health Care Workforce Regulation. Policy Considerations for the 21st Century*. Pew Health Professions Commission, San Francisco, California.

GRAGNOLA, CM & STONE, E., (1997) *Considering the Future of Health Care Workforce Regulation.* UCSF Centre for Health Professions, San Francisco, California.

HILMER, FG, (1993) *National Competition Policy,* AGPS, Canberra

INTERNATIONAL COUNCIL OF NURSES, (1986*) Report on the Regulation of Nursing,* Geneva, Switzerland.

INTERNATIONAL COUNCIL OF NURSES, (1997) *ICN on Regulation: Towards 21st Century Model*, Geneva, Switzerland.