HEALTH PRACTITIONER REGULATION NATIONAL LAW (WA) BILL 2010

Declaration as Urgent

DR K.D. HAMES (Dawesville — Minister for Health) [4.21 pm]: In accordance with standing order 168(2), I move —

That the Health Practitioner Regulation National Law (WA) Bill 2010 be considered an urgent bill.

I apologise to the Deputy Leader of the Opposition for not being as quick as I should be in moving this motion.

The reason that this bill needs to be declared an urgent bill is that it is a national law bill. Originally it was passed in Queensland and has been accepted and passed by the Parliaments of all the other states, barring South Australia and Tasmania, both of which had elections, which slowed the passage of their legislation. Queensland's bill enabled the establishment of a large number of bodies under national law—national health agencies and boards. All these bodies have been created in anticipation of every state agreeing to and passing this bill by 30 June 2010 so that it can become law on 1 July 2010. Western Australia is lagging behind. Part of the reason for that is an administrative one. Changes were made to the drafting personnel and that delayed this legislation being ready. Another reason is that some of the other states accepted the Queensland bill as the law for their state. This government decided to have what is called mirror legislation, whereby the legislation must be passed as Western Australian legislation. Therefore, the legislation was redrafted along those lines, which meant that any changes to the legislation requires the Western Australian government to accept those changes rather than them automatically becoming national law. It is important that we get this legislation through this Parliament by 30 June for it to become national law on 1 July.

The bill is detailed and we do not anticipate that having such a large bill will be necessarily easy. That is always the way with national legislation. The direction that this legislation has taken was agreed by the Council of Australian Governments—all the Premiers of Australia. All health ministers are now putting in place what was agreed at a national level when the former government and current national government were in office.

MR M. McGOWAN (Rockingham) [4.25 pm]: The opposition agrees to declaring the Health Practitioner Regulation National Law (WA) Bill 2010 an urgent bill. However, it is not a particularly good way to run a Parliament for the government to seek to declare as urgent what is, in effect, not particularly serious legislation simply because it has not managed the parliamentary timetable to get it before the Parliament to allow sufficient time for appropriate debate and consideration. Ordinarily an opposition, other parties and government backbenchers should, at a minimum, be given at least three weeks to consider a piece of legislation following its introduction to Parliament. In this instance that period is being truncated. The best example that I can recall of that time being truncated was in the days of the Gallop government when terrorism legislation was introduced as part of a national arrangement. A similar scenario might have taken place for gun law legislation. Matters of a national imperative that involve concerns about the national security of our citizens are obviously some where urgency is required. In the case of this legislation, the minister said that the reason this bill should be declared an urgent bill is that it was not drafted in time. That is not a particularly good reason.

Dr K.D. Hames: I accept that.

Mr M. McGOWAN: I appreciate that the minister accepts it. The opposition could be difficult on the basis that it is not a good way to run the Parliament. However, we will agree to it in the normal constructive spirit of the opposition—the minister can laugh. Last time this house sat, question time was closed down after the second question that had been asked by an opposition member. It is entirely open to us not to be cooperative on this occasion, especially considering that, from memory, it was the first time that question time had been closed down after a small time for debate. Question time provides the opportunity for ministers to be questioned. I think all members opposite were to a degree embarrassed by the fact that we were not able to ask questions of ministers on matters that come under their portfolio, which, as all members know, under the Westminster tradition is one of the most important ways for ministers and a government to be held accountable. Even the Commission on Government agreed with that. We did not get that opportunity.

Mr C.C. Porter: Did you cancel pairs?

Mr M. McGOWAN: We did cancel pairs. I am glad that the Attorney General asked that question. We cancelled pairs, with the exception of one or two government members, because, as members would be aware, there were exceptional reasons why they could not be in the house that day. We were understanding of that. I note that there was a degree of sheepishness among government members. The Attorney General was not in the house at the time. The Leader of the House was sheepish to a degree because of what took place that afternoon. All members know that ministers should be required to answer questions during question time. I note that the Leader of the House was not particularly hostile towards me that afternoon, because he knew that what I was

doing and saying was fundamentally correct and he agreed with it even though he knew he could not vote for it. Some of the government's senior members may have even communicated words to the effect to me.

Why did we go through the rigmarole of cancelling pairs and saying that we would not provide Acting Speakers to assist in the operation of this house? It was because if the opposition is to be treated that way in this house, its members will react. When the Premier was in the role of the Leader of the Opposition, he was far more difficult than that over far less significant things than the closure of question time. As members know, question time is the most important part of the day for the opposition and it is the most important part of democracy in action. If action is taken, the opposition will respond, and on that occasion it did so accordingly. That is what happened. We moved a motion and the Attorney General did not support it. It was an occasion on which the Attorney General could have done the right thing, but he elected not to. I realise he was not in the house at the time and it was not his decision. However, if he had been here, I know that, as a man of principle, he would have done the right thing. For the record, that was a joke.

The opposition will be supportive on this occasion. It acknowledges that it is doing the right thing by the government.

DR J.M. WOOLLARD (Alfred Cove) [4.30 pm]: I am very disappointed that this legislation is being rushed through this house. I thank the Minister for Health and his staff for the briefing that they gave me on this bill. However, there are still many questions and many areas of this bill that I would have liked to have had researched before this bill is debated in the house. I would have liked to have had discussions with the Attorney General, and further discussions with people in New South Wales and in the other states about how this legislation is being implemented. The minister has given an implementation date of 1 July. As members would know, I am a registered nurse. Last week I received from the Nurses and Midwives Board of Western Australia a letter telling me that this bill is being passed through the Parliament and there will be national registration. The letter basically said that if this bill does not come into effect on the agreed date, nurses do not need to worry, because the current legislation will still be effective. Having spoken with medical colleagues, I know that they received exactly the same letter as I received. Therefore, I do not believe that there is the urgency with this bill that the minister is saying there is. I have not had the opportunity to fully discuss the content of this bill with the Minister for Health and his staff, the Attorney General, and health professionals. I would have appreciated being given more time to have those discussions and do that research. It is important that we scrutinise legislation properly and not just rubber-stamp it. I believe that in rushing this legislation through the Parliament we are rubber-stamping it and not giving it the full scrutiny that it deserves.

MR R.F. JOHNSON (Hillarys — Leader of the House) [4.32 pm]: I had not intended to take part in this very short debate on the simple question that this bill be considered an urgent bill. However, I cannot let the comments of the manager of opposition business go by without reminding him of some things that he tends to forget. The member for Rockingham gave us the reason why he instructed his Whip to cancel pairs following the decision of the Speaker to cut question time short the week before last. I want to remind the member for Rockingham of something that happened when Fred Riebeling was the Speaker and we were in opposition. On one occasion Fred Riebeling also cut question time short. I then moved that so much of standing orders be suspended as would allow me to ask the following question; and I asked my question. I want to tell the gentlemen—and ladies—opposite what happened. They did not support that! They supported the Speaker of the day —

Mr P. Papalia interjected.

The ACTING SPEAKER (Mrs L.M. Harvey): Order, member for Warnbro!

Mr R.F. JOHNSON: They supported the Speaker of the day—which is what I think governments have to do in a responsible way. We did the same thing. The leader of opposition business wants to in some way punish us by not giving pairs. We did not abandon pairs when the then government did not support us when we asked to carry on with question time when Fred Riebeling was the Speaker. I also remind members opposite that Fred Riebeling used to throw members of our party out on a regular basis!

Mr W.J. Johnston: You deserved it!

Mr R.F. JOHNSON: If anyone deserves to be thrown out, the member for Cannington is a classic case! He really is! He is a constant interjector. All we ever hear over here is constant verbal diarrhoea coming from that particular part of the room, quite frankly. If I was in the chair, I would certainly throw out the member for Cannington!

Mr W.J. Johnston interjected.

The ACTING SPEAKER: Order, member for Cannington!

Mr R.F. JOHNSON: I want to remind the manager of opposition business that we normally try to be fair in this house, no matter what side of the house we are on.

Mr M. McGowan: We are being very fair to you today!

Mr R.F. JOHNSON: No! The opposition cancelled pairs. It is not giving us the pairs that are the normal convention.

Mr M. McGowan: We are not debating that.

Mr R.F. JOHNSON: The member for Rockingham is the one who started this debate.

Mr M. McGowan: We are not debating that.

Mr R.F. JOHNSON: The member for Rockingham started it. He did! The problem is that the member for Rockingham has a very short memory. He has a very selective memory. I suggest that he look back at *Hansard*, because then he will see exactly what happened when he was on this side of the house and we were on that side of the house.

Mr M. McGowan: What about the things you did?

Mr R.F. JOHNSON: Oppositions get up to things. Of course they do. We accept that. But governments have to be the responsible people.

Mr M. McGowan: I remember that you stormed out of the tourism estimates, and you winked at me as you stormed out!

Mr R.F. JOHNSON: Did I?

Mr M. McGowan: What an outrage, you said, and you stormed out—and you winked at me!

Mr R.F. JOHNSON: That just shows what a nice sort of guy I am! I remind the member for Rockingham that there are times when we change places in this house. There will be a time, in many, many years to come—if it is not before the member for Rockingham's retirement age—when he will be back on this side of the house; and then he will have a different view on life, I am sure. So I just ask the member for Rockingham to be a reasonable person and a responsible manager of opposition business, and observe the conventions of Parliament.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [4.35 pm]: As the member for Rockingham has stated, we will be supporting the motion that this bill be considered an urgent bill. However, we do so reluctantly. I support the comments made by the member for Alfred Cove. This is a substantial piece of legislation. It is actually legislation that will make some substantial decisions on behalf of not only this Parliament but future Parliaments. From that point of view, we agree to this bill being considered an urgent bill, because there is a national imperative here. We acknowledge the efforts of the Minister for Health to make sure that Western Australia is part of that national program. But we assure the member for Alfred Cove that we will be applying whatever scrutiny we can, given the limited resources of not only the member herself but also the opposition, to make sure that we are satisfied that this bill does what it intends to do and is consistent with the agreements of the Council of Australian Governments.

As I have said, this is a substantial piece of legislation. We have questions about this legislation. We look forward to the minister assisting not only the member for Alfred Cove but also ourselves to dig into the detail of this legislation, hopefully in a swift and forthright manner, so that we can be assured that the consequences of this legislation will not be as some of the stakeholders in this debate have suggested. We assure the member for Alfred Cove that we, like her, will be putting this legislation under as much scrutiny as we can, given the time available to us. We look forward to the minister assisting us in building our understanding of this legislation, and in making sure that we as a collective chamber in this Parliament are making decisions that are informed and in the best interests of Western Australia.

Question put and passed.

Second Reading

Resumed from 5 May.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [4.37 pm]: I rise to speak once again on the Health Practitioner Regulation National Law (WA) Bill 2010. As I have said, this is a substantial piece of legislation. The documentation on this bill comprises over 350 pages. There is a substantial amount of detail in relation to not only the bill itself, but also the consequential legislation and the repeal and amendment of other acts of Parliament. That makes this a very difficult piece of legislation to get one's head around. It is for that reason that we have been proceeding with some caution in our attitude to this bill. We have sought information

where we can, not only through the briefings that we have received from the government, but also from the stakeholders who have an interest in this legislation.

Of course the bill itself comes out of a process undertaken by the Productivity Commission in 2005 to examine the professionals in the health workforce and see what inefficiencies could be identified and what efficiencies could be gained, particularly in relation to the accreditation and regulation of health practitioners throughout the country. In January 2006, the Productivity Commission delivered its report, and subsequently, in July of that year, the Council of Australian Governments agreed to establish a single registration scheme for health professionals. It is easy to say that we will create a single registration scheme for health professionals; it is much harder to do. In my observation of the process, we have come forward with this legislation and these regulations to a point in the policy cycle where there is not a single interest group, stakeholder, state government or department that does not have some reservations about the way the law will be applied.

We are trying to bring together the disparate regulatory schemes that exist in each of the states after a long period of self-regulation, of building traditions, custom and practice, and of some good old-fashioned state prejudices, and we are overcoming some great obstacles in the process. It is perhaps remarkable that in such a short period we have come to a point at which we have legislation that will be exercised by Parliaments across the country in the exact same form, to overcome one of the typical tyrannies of the Federation.

I must confess that I have some concerns about that process; it has been put to me by a number of people that, "If it ain't broke, why fix it?" That is, if we are already achieving high standards in the health professions, if we already have mutual recognition of the accreditation schemes that exist in each of the state jurisdictions, and if we already have a system that people are, by and large, happy with, why are we going to such great lengths to bring about a single system? It is imperative that we have an economy that drives towards efficiency in all areas, and health must make a contribution to that as well. It is important that we have an accreditation and regulation system that is consistent throughout the country. It must be an odd thing indeed for health professionals who come here from other countries to see the very different ways in which we go about the regulation of health professionals in each of the states, notwithstanding the tradition and mutual recognition that exists between them.

It is perhaps not necessarily the most pressing of legislation; it is not an area that a newcomer to the health debate would identify as being the highest priority. However, it is an important part of the national health reform agenda. Labor is very proud to be taking such a comprehensive approach to the national health reform process to bring about change, efficiencies and productivity in a range of areas of the health system. We are driving towards synergies and efficiencies and hopefully, in that process, will drive a better health system right across the country. It is only fair that the Health Practitioner Regulation National Law (WA) Bill 2010 make its contribution to the national health reform debate. Indeed, it is a very substantial piece of legislation, if not a headline-grabbing reform.

The timing of the bill is unfortunate; the member for Alfred Cove has made known her grave misgivings about the speed with which we have to approach this legislation. I acknowledge the comments made by the Minister for Health about the difficulties he has had in bringing this legislation to this place. I think it is unfortunate that we are taking such a substantial step in the lives of health practitioners across the state and in the state–federal relationship in the reform agenda in such a speedy manner.

Let us be clear about what we are doing with this legislation: we are taking a range of areas of operation of state law and ceding them to the federal sphere of government. Once ceded, they will never return and we will forever be subject to this legislation. It is fair to say that, to a certain extent, this Parliament is giving over some powers to the federal Parliament.

Dr J.M. Woollard: Some powers?

Mr R.H. COOK: We retain many others.

Dr K.D. Hames: It's got nothing to do with the federal government; it's a federal body.

Mr R.H. COOK: I acknowledge that technical description of it, but it is fair to say that we are ceding powers on behalf of the Minister for Health to a national system, over which the minister will have substantially less control.

Dr K.D. Hames: That's true, but it's not to the federal government.

Mr R.H. COOK: Yes, granted.

I acknowledge the member for Alfred Cove's anxieties; as a member of Parliament, she wants to take this step with great care. These matters are currently wholly within the sphere of this government and this Parliament, but from this point forward they will be placed in the control of a larger collective over which we will have less

control. One might argue that that could be a good thing. What we are actually saying is that the conduct of health professionals in Western Australia should be part of a broader scope. As a nation, we want to know that a clinical psychologist in New South Wales is acting with as much care, rigour and professional discipline as a psychologist in Western Australia. As a nation, that is a fair aspiration. In doing so, we are ceding some control over the process to a collective group of authorities over which we will have less control.

The Minister for Health and members of the Department of Health, in providing briefings to members, have already, in spirit if not in so many words, acknowledged some frustration in dealing with what will now be a broader range of jurisdictions to meet our aspirations for the conduct of health professionals in this state. From that perspective, let us be very clear about what we are doing: we are taking what is now solely under our control, and providing it to a broader group of jurisdictions of which we are just one part. Without actually saying that this might be a good thing in one case but a bad thing in another, we, as a Parliament, should be very clear about this. To the extent that a state has a level of sovereignty, we are ceding some of that sovereignty and control. This is a step that we must take with some care. In that respect, the timing and haste of this bill is really quite regrettable because we will not in future have the opportunity to say that we took this very important step with great care and a precise understanding of the information in front of us.

This is one of the concerns that members of some of the health professional groups in Western Australia have communicated to me and, I am sure, to the minister. I know that such concerns have been communicated to my colleagues on this side of the chamber as members of Parliament. They are concerned that some of the changes we will be making will negatively impact upon their professions, and that is unfortunate.

It is true to say that the Minister for Health has gone to substantial lengths to address the concerns of these particular health professional groups, and that has been acknowledged to me by a number of health professionals—namely, that the minister has done his best in his negotiations with other jurisdictions to bring about changes that may take better account of particular aspects of Western Australia's health professional accreditation system that we wanted to be accommodated within the national scheme. It is also fair to say that he has not been wholly successful in that task. We must undertake another task on behalf of the people of Western Australia, in particular on behalf of the health professionals who are impacted upon by this legislation by saying, notwithstanding their concerns or whether we agree with their concerns, that we are moving forward nonetheless. From that perspective, we must also move forward with care. It is from that perspective that it is regrettable that we have to do this in such a short period. There are concerns. We know there are particular concerns from the community of psychology professionals in Western Australia, from the medical fraternity represented by the Western Australian branch of the Australian Medical Association, and from the physiotherapy and dental professions in this state. Under this legislation, physiotherapists and dentists will have their day in court, so to speak. I do not know whether that is the best way to describe it, but they will have their day in court as the Australian Health Ministers' Conference will consider how they go about the accreditation and regulation of those professions further down the track.

Dr K.D. Hames: I am aware of the concerns of psychologists and physios but I am not aware of dentists having a problem.

Mr R.H. COOK: Fair enough. From that perspective, members on this side will pass this legislation and place in the minister's hands the best endeavours and responsibility to achieve the appropriate outcomes for those health professionals in this state.

Dr K.D. Hames: You could help, of course, by convincing your colleagues in other states.

Mr R.H. COOK: The minister cannot have it both ways! They cannot all be his best friends one minute and then he throws up the white flag and seeks our support on another issue! The minister has talked at length about the influence he has over the national health system and the great resources that he brings to this state by the closeness of his relationship with both the federal government and the other health ministers. The opposition will be looking with great interest at how the minister exercises that substantial influence into the future, and it will ensure that he is upholding the interests of health professionals in this state.

There are concerns about this legislation, and these have been communicated to us by a number of professional groups. One of the groups that is most disturbed by this legislation is the clinical psychologists. It has been my experience when coming into these sort of debates that if we are transferring from a collective of state regulatory regimes to a national regulatory regime, it is only appropriate that we seek the highest possible standards in that process. It is not appropriate that we use that process to lower standards in any one state. This process should be used as an opportunity to make sure that in each of the jurisdictions, we identify the differing levels of regulation—in this case the differing levels of best practice—and that we raise the standard and improve the effectiveness and level of accreditation of health professionals. The concern of clinical psychologists in Western

Australia is that we have done the opposite and we have missed that opportunity, and what we are doing is taking the standard of accreditation of psychology in Western Australia and lowering it to that of the other states. The clinical psychologists argue that not only are we lowering the standard, but we are lowering it to a level that will take it below the recognised international standard to which we should aspire. I am not an expert on the various regimes of psychology that exist internationally, but I would have hoped that that was the very least of our aspirations through the Health Practitioner Regulation National Law (WA) Bill; that is, that we were joining a regime that took the nation as a whole to a higher standard. However, we see specialist categories of psychology in Western Australia reduced to an area of endorsement, rather than specialisation; namely, the areas of endorsement for specialisation being reduced from nine to seven.

Some very sincere and valid concerns have been expressed by this health profession group in relation to these laws. In fact, it has been put to me strongly by a range of clinical psychologists that we should be going alone, and if it is the case that the national regime is lowering the standards of psychology in this state, we should not be joining the process; instead, should stick it out as a separate jurisdiction to maintain standards in this state. They say that in the absolute knowledge that they would potentially be paying two sorts of fees—one to be registered in Western Australia and one to receive national accreditation. But they do so safe in the knowledge that under the Western Australian laws they would have a greater recognition of their specialist training and that they would be upholding the standards of this state. It is fair to say that the attitude of a range of clinical psychologists to whom I have spoken has been soured somewhat through this process by the experiences of watching the national board in action. I am assured that the nominee that was put up by the state board to the national board in relation to psychologists in Western Australia was knocked back, and that Western Australia is, in fact, the only state in which the state board's nominee for the national boards was knocked back. Obviously, there will be an opportunity for the minister to assure us that this is not the case, but if it is the case, that point needs to be resolved. The minister certainly needs to respond to why the state board of psychology is being replaced with a regional board that shares its jurisdiction with South Australia, and why it is considered appropriate to retain regional boards in this case and no longer have a state board to oversee psychologists in Western Australia. There are some anxieties in this state as a result of some recent media reports about the nature of psychology in this state from some consumer experiences, and I thought that the last thing we should be doing at this point is watering down arrangements in this state. Again, if this is not the case and we are not watering down the standards for psychologists in this state, members on this side stand ready to be assured and to have the issue clarified by the minister. As I said, the clinical psychologists to whom I have spoken have assured me that the standards for clinical psychologists in this state meet the Organisation for Economic Cooperation and Development standard, which is a four-year degree followed by two years of supervised clinical practise followed by specialised study. My understanding is that under this legislation and under the rules that have been developed for clinical psychologists that would no longer be the case. A psychologist would merely now have to come out with a four-by-two degree and that would be considered sufficient. However, the psychologists to whom I have spoken do not consider that will be sufficient. They have suggested to me, as I have said in this debate, that we not repeal the Psychologists Act 2005 but retain it so that we can maintain separate supervision of psychologists in this state. We understand that this would make the registration of psychologists in Western Australia no longer valid under the national scheme, but the psychologists I spoke to consider that a fair price to pay if it means that we will retain our standards.

I am assured by the psychologists to whom I have talked that 80 per cent of the complaints against psychologists in this state are for those who undertake practice after their four years of study with two years' supervision and without further specialisation. Therefore, these psychologists are telling me that what we are actually doing is placing the capacity and the standards of the profession in danger. That is represented by the fact that 80 per cent of the complaints lodged by consumers of psychological services in Western Australia are for these lower level trained psychologists.

Mr P. Abetz: What percentage do they make up of total psychologists?

Mr R.H. COOK: The four by twos? I do not have that information, member, but it is obviously a concern—I can see the member for Alfred Cove smiling at me, so it seems like she has that information and I look forward to her contribution to the debate—of the psychologists with whom I have been meeting that what would be considered the gold standard will be this group from which, in their experience, has suffered the largest number of complaints.

However, I think by far the most concerning of the worries raised by the psychologists is the fact that membership of the Australian Psychological Society will, under the national scheme, automatically give psychologists accreditation under the Psychology Board of Australia. This direct transfer means that we will be in a situation whereby all those people who are currently members of the Australian Psychological Society will automatically receive accreditation. That is worthy of concern when we look at the membership of the Australian

Psychological Society and reveal that many of its members do not have postgraduate degrees. Some of its members do not have degrees at all but through grandfathering clauses became members of the Australian Psychological Society and, as a result of that, will now be accredited under the national scheme under further grandfathering clauses. Therefore, people without qualifications will be accredited under the national scheme. That should sound alarm bells and the red light should be flashing on the minister's desk so that he says, "Hang on, it's perhaps time to put the brake on this aspect of the national process." What appears to be happening is that by trying to capture such a wide range of jurisdictions in the area of psychology, we will lower the standard in Western Australia. That, I might say as a member of Parliament, is just not good enough. From that perspective, the opposition will be examining that aspect of the legislation very carefully and we will look to the minister to provide us with a reason why we should not move to delete the repeal of the Psychologists Act 2005, because that is indeed a very important issue that has been raised.

It is also fair to say that the medical fraternity has some anxieties about the Health Practitioner Regulation National Law (WA) Bill 2010. Of all the health professions in Western Australia, there can be none prouder than the general practitioners and doctors who are members of the Australian Medical Association of Western Australia. I have had some very animated representations from the AMA about this bill, and I am sure that the minister and certainly the member for Alfred Cove have also been subject to some of those representations. The minister has assured both the AMA and me that he has gained concessions out of the national accreditation process to ensure that we have captured as best we can the concerns that the AMA has about this process. However, the AMA has some significant concerns, particularly about the way it will impact on the Medical Board of Western Australia. The AMA has made it clear to me that it would like the complaints process for Western Australia managed and held in Western Australia. It is true to say that under the national system that will be the case; the complaint function will be delegated from the national board to the state board. However, it is of concern that this is not anchored in legislation in Western Australia and therefore that that might not always be the case. There is a concern that in the future we could possibly cede the delegation that goes to the state board; that is, it would be withdrawn by the national board. The AMA does not believe that that is an appropriate function for a board that has functioned for—I am sure the minister could probably tell me—perhaps more than 100 years in Western Australia; it has certainly functioned for a long time and, to the best of my knowledge, it has functioned pretty jolly well.

I understand that under the national process, the assets of the current state board, valued in the area of about $2 million, will also be ceded to the national board. Although I do not think that the flight of that amount of money will necessarily devastate the economy of Western Australia, it is obviously of concern and galling to those practitioners or health professionals who have spent many years building up the solid base of accreditation in Western Australia to see the assets of the Medical Board of Western Australia move east.

I understand that in New South Wales the state board manages the complaints system and that is anchored in legislation. I think it is the New South Wales model that the AMA was looking to have adopted in Western Australia.

Dr K.D. Hames: No, that is not true. The New South Wales model is a totally different model. None of the other states want to do that. New South Wales has decided to move its total system out and the AMA is talking about us doing the same.

Mr R.H. COOK: Therefore, we would have a totally separate system as well. The legislative process by which we could do that, I suppose, is academic at this point. However, the AMA is trying to say, "Hang on, let's keep this in WA and let's make sure the legislation ensures that this stays in WA. We've been doing a good job to date; we will continue to do a good job."

Dr K.D. Hames: Right, but that has to be changed federally, not at the state level, to achieve that.

Mr R.H. COOK: The AMA is also concerned that the word "physician" has not been captured in the national legislation under the range of what are referred to as protected titles. It is of the view that physician should be a sacrosanct title that is protected under legislation and it is concerned that that has not taken place. The AMA is also concerned that the legislation refers to best standards in terms of accreditation and it believes, like us, that we should be looking at best practice in terms of the profession rather than merely meeting a standard.

However, I think some of the AMA's major concerns are saved for the mandatory reporting aspects of the legislation, which require health professionals to report concerns about malpractice, regardless of the circumstances they find themselves in. It has been put to me that many members of the Australian Medical Association will have partners, close colleagues or friends who also are accredited health professionals. A health professional who is married to another health professional, such as nurse or another doctor, might treat a client while being on some form of medication. That could give rise to some concerns about the nature of the treatment given. The partner could be suffering from mild depression and might not have been in the best condition to treat

a patient on that day. Should that type of scenario be subject to mandatory reporting? It has been put to us that that would be an unnecessary and burdensome onus to put on health professionals. It also has been put to me that this comes down to the issue of the highest standard of patient care, and I am sensitive to that argument. The AMA has identified a very important point regarding the mandatory reporting requirements but it is also fair to say that the minister should aim for the highest possible standards. Therefore, we are not in a position to suggest changes to the mandatory reporting requirements.

The AMA has also pointed out that under this legislation spent convictions could be taken into account when considering whether one is a fit and proper person to be a health professional. The national legislation empowers a national board to seek the details of the criminal record of a health professional. The criminal record, as well as spent convictions, may be used to determine whether it is appropriate for that person to be accredited under the person's profession. It has been put to us that this is a very grave move and could possibly endanger someone who has done his time and repaid the community for what might be a very minor misdemeanour. He could be punished in a professional context by being refused accreditation under this legislation. That is a very acute interpretation of how the regulations may be looked at. We will certainly seek the assistance of the minister to give us an understanding that the safeguards that may be put in place to ensure that the overuse of spent convictions will not be a feature of this process, and that someone who has received a spent conviction will not have his accreditation withheld unnecessarily simply because of an extreme interpretation of the powers the board might have regarding that information-gaining function.

The AMA has acknowledged that it has had discussions with the minister and has expressed its concern for and disappointment about the extent to which the minister has gone to meet the AMA's concerns. It has said publicly that in its present form this legislation may impact seriously upon medical training by removing the independent accreditation, lowering standards to appropriate quality rather than best practice, and by failing to insert a public interest test for the accreditation of medical professionals. More concerning, however, is that the president of the AMA has said that this could result in a lower standard of patient care in Western Australia. The Labor opposition is concerned about that and seeks clarification and an assurance from the minister that that will not be the case. We seek assurances that the minister has made representations to the ministerial council and has satisfied himself that patient care will not be endangered by these regulations and that we will get the best possible outcome for Western Australia under this legislation.

It has been put to me very forcefully that we simply must pass this legislation. We are told that to not do so would endanger Western Australia's participation in the national scheme. We are told that we might find ourselves sitting outside the glorious house of national health accreditation knocking on the door seeking to come in if we do not pass this legislation within the desired time frame. I believe that to be untrue and that that is putting unnecessary pressure on Parliament. If we do not pass this legislation in the time required, we can simply take our time to consider the legislation in the long term. If we do not join the national scheme by 1 July, we could do so by 31 October. I do not believe that the other jurisdictions would say that they were not ready for us to join them even though we had passed the legislation and done everything that was required and the minister continued to be part of the forum. That would not happen. The other states would thank us for our best endeavours for getting this legislation through in a timely process. They would be sorry that we did not meet the 1 July deadline but would be glad that we were able to join the other states by the 31 October deadline. If that is what is needed to ensure that this legislation is appropriate and meets all the concerns that have been voiced about it, so be it.

The minister is confident that he will be able to satisfy both houses of Parliament that the legislation is appropriate for Western Australia; that it meets Western Australia's requirements regarding the impact it will have on Western Australia; that it meets the concerns of the health professionals while not lowering the standards of psychology in Western Australia or putting our medical practitioners in an invidious position; that it properly represents Western Australia's interests; and, even though we will forever cede a large amount of control, meets Western Australia's public interest. We look forward to that. As I said, this is very substantial legislation. From that perspective, it is unfortunate that we have had such a short time to examine it.

It is important for Western Australia to be part of the national health reform agenda and to take centre stage and be part of the driving force for reform in Australia to make sure that Western Australians can access the very highest standard of health care in this country. It is important also that our health professionals who are working in this area can do so with the very highest level of accreditation and that they can meet the highest level of standards that are not dumbed down because we have become part of a national scheme. It is important that we are assured that when patients present to a health professional, their care is not compromised by this national accreditation scheme; and that when those patients validly or rightly complain about a health professional, their rights are not compromised by virtue of the fact that we come under a national scheme after this legislation is passed and that they receive a timely and appropriate response to those complaints.

The minister has taken on the very large task of assuring us that all the ducks are lined up and that this legislation will indeed do all those things: it will not dumb down state standards by virtue of being part of a national scheme, it will provide the highest level of accreditation for our health professionals, it will not compromise health care and it will not compromise the rights of people receiving health care in this state. Once we pass this legislation, it will be gone. Then we will have to rely upon the best endeavours of our state government, our state ministers and our state government departments to ensure that the interests of Western Australia are protected and that the standards under our state system are maintained, and are certainly no lower than they have been in the past and are preferably higher as a result of being part of a national system. We look forward to providing the closest level of scrutiny to this bill that we can. We look forward to the minister providing us, in the spirit that we have brought to this debate, with the information and assurances that we seek. We look forward to the other stages of this bill so that we can assure ourselves and the people we represent that this is the best move for the health system as part of our participation in the national reform debate and the best way that we can move forward as a Parliament.

DR J.M. WOOLLARD (Alfred Cove) [5.22 pm]: Once again, I thank the Minister for Health for the briefing on the Health Practitioner Regulation National Law (WA) Bill that was given by his staff. However, I have grave concerns about the bill. As I have said previously, I am a registered nurse. Not only am I a registered nurse, but also I am a former president of the Australian Nursing Federation. I will look at what this bill will introduce and I will provide some examples of the failures that I can see in this legislation because of my past experience.

There are three main areas in the legislation that I am concerned about. The first relates to standards. I believe that having a national body will decrease the standards. I say that because when I was active with the Australian Nursing Federation, I was a member of the professional development committee. As a member of that committee, we developed standards and competencies for nurses in Western Australia. I know that the standards and competencies that we developed in Western Australia were far higher than the standards and competencies that applied in other states. I believe this bill will remove our ability to have input on those standards and competencies. I thank the minister's staff for a copy of the letter that the minister received from the Medical Board of Australia. It states —

> Dear Minister
>
> **Delegation of management of notifications to the Western Australian Board of the Medical Board of Australia**
>
> …
>
> The Medical Board of Australia … has considered how it will delegate various powers under the *Health Practitioner Regulation National Law* … The National Board has agreed that it will delegate all powers relating to individual registrants to the state or territory Board. The National Board's role will be to develop and approve registration standards, codes and guidelines, approve accreditation standards and negotiate the health professions agreement.

The national board's role will be to develop and approve registration standards, codes and guidelines, approve accreditation standards and negotiate the health professions agreement. That will be taken away from all the health professions here. Although there are many ways in which we can improve our health care services in Western Australia, we are ahead of many other states, particularly in relation to standards of care, because very dedicated health professionals work in those areas. I will come back to my areas of concern as we deal with the different clauses of the bill.

The next issue is costs. I believe that costs will increase as a result of national registration. I am disappointed. I understand that we are in this position because some two years ago, a previous Premier signed an agreement with the Council of Australian Governments. In that agreement, the previous Premier ceded not only 30 per cent of the goods and services tax, but also 100 per cent of health regulation legislation.

Several members interjected.

Dr J.M. WOOLLARD: He ceded that power, having sat in this Parliament and looked at legislation for nurse practitioners and medical practitioners. I think it had been 17 years since the Medical Practitioners Act that was brought before Parliament two years ago had been reviewed. Over the past decade, this Parliament has been looking at health professionals legislation and has been amending Western Australian acts. Although I argued against some of those amendments because they did not go far enough, I believe that we should have kept registration at a local level. I think this is going to cost us. As I said, this is going to remove the state's powers in relation to registration, accreditation and discipline.

I hope that the Minister for Health, possibly following debate on this bill, and in the time it takes for this bill to go to and be reviewed by the upper house, will give serious consideration to some of the issues raised by the

member for Kwinana that have come from various health professionals, including psychologists. I know that the dentists in Western Australia are not happy with ceding their powers. I believe that pharmacists feel the same. Some health professionals have accepted national registration and accreditation, but not all groups have done so. I believe that a bill that is going through the New South Wales Parliament today that provides a major change to the way in which the bill was introduced, and makes changes related to complaints and discipline. I believe that legislation will be tabled in the New South Wales Parliament today. I would like to look at that legislation to ascertain whether New South Wales has a different complaints mechanism. Another reason that I would like to see the New South Wales model is that some of Western Australia's health professionals would like to maintain the complaints and discipline mechanism that is in place in this state. I would like the opportunity to discuss the New South Wales model with health professionals to determine whether it could be modified to provide them with the autonomy to ensure that their high standards continue.

It looks as though the second reading of the Health Practitioner Regulation National Law (WA) Bill 2010 will be passed in this place tonight. I have people trying to obtain a copy of the New South Wales bill for me, but I do not know whether I will receive it in time to consider it in detail.

Dr K.D. Hames: That bill was passed a year ago in Queensland. You can get a copy of it. It has gone through the other states. It is mirror legislation. It has, in fact, been available for a year.

Dr J.M. WOOLLARD: The minister said that this bill is mirror legislation. When we come to consideration in detail, I will point out to the minister that the Western Australian bill is not mirror legislation. I have a copy of the Queensland legislation and the Western Australian legislation, and I have not had sufficient time to compare them clause by clause. I have looked at a few clauses, and the bill we are debating is not mirror legislation.

Mr R.H. Cook: Is the New South Wales legislation that is being tabled today complaints legislation?

Dr J.M. WOOLLARD: Yes; it does relate to complaints. I want to read that legislation because I know that the Australian Medical Association would like to keep the complaints mechanism separate. Maybe we could look at how complaints are currently managed under this state's medical act. Perhaps the relevant section could be removed from that act and inserted into this bill. However, we are unable to do that because the sections of the medical act relating to complaints and discipline refer to the Medical Board of Western Australia. However, under this bill the proposed medical board would be a completely different entity to the Medical Board of Western Australia. I could not ask the minister to remove the relevant section from the medical act and insert it into this legislation, because I would need the time to carefully consider how the complaints and discipline mechanisms would work in light of the fact that the medical board referred to in this state's medical act would no longer be the medical board referred to in this bill. I repeat that the medical board referred to in the Health Practitioner Regulation National Law (WA) Bill 2010 will come under the national board.

The intergovernmental agreement for a national registration and accreditation scheme for the various health professions states —

> The State of Western Australia will, as soon as reasonably practicable, enact corresponding legislation —

The following are the key words —

> — substantially similar to the agreed model, so as to permit the scheme to be established on 1 July 2010.

I repeat: it is substantially similar for registration and accreditation.

[Member's time extended.]

Dr J.M. WOOLLARD: However, this house has previously considered national legislation. For example, I refer to the National Gas Access (WA) Bill 2008. That bill was introduced by the Premier and in his second reading speech, when he was talking about what was going to happen and how the legislation related to Western Australia, he said —

> Western Australia will also retain the Economic Regulation Authority and the Gas Disputes Arbitrator respectively as regulator of and arbitrator for gas transmission and distribution regulation. These functions will be handled by the Australian Energy Regulator in other jurisdictions. These two departures from the national regime require Western Australia to modify the text of the National Gas Law to allow for Western Australian institutions and a stand-alone access regulatory regime if other jurisdictions move beyond access issues.

Through this bill the government may be locked into a national registration and accreditation scheme, but it has not considered the lowering of our standards. That is the reason I am very concerned that we have had only two weeks to look at this 300-page measure. I repeat that two weeks has not been long enough to compare the clauses in this bill with the clauses in similar legislation in other states or to discuss it with health professionals.

Western Australia is obliged to enact substantially similar legislation, but this bill can be amended. That is the reason I will, in consideration in detail, put some amendments on the table. I have not had the opportunity to fully discuss some of my amendments with the Attorney General. I have briefly discussed some of them with him in the house. He is hopeful that when we debate those clauses, he may be able to join in on the discussion.

The Australian Health Minister's Advisory Council advised that Western Australia must use its best endeavours to submit legislation that will not be inconsistent with or alter the effect of the national legislation. Again, paragraph 6.8 of the intergovernmental agreement states —

> The States and Territories will use their best endeavours to ensure legislation as appropriate provides for entities in their jurisdiction to investigate and hear serious disciplinary matters and the hearing of appeals against less serious disciplinary matters —

I turn now to other aspects of this bill. Again, I have not had sufficient time to look at this bill in detail. However, the definition of the terms that are used should be consistent throughout all the acts that will be amended by this legislation. However, that is not the case with this bill. This relates to only minor things, minister.

Dr K.D. Hames: That is because each state will have a different act.

Dr J.M. WOOLLARD: No, minister. The definitions in some of our acts vary.

I turn now to proposed section 3 of the Health Practitioner Regulation National Law, which is found in the schedule to the bill. That section is headed "Objectives and guiding principles", and it deals with the determination of standards. I know, from when I was a member of a committee of the Australian Nursing Federation, that the Western Australian standards in nursing are higher than the standards in the other states. I believe from the discussions that I have had with the Australian Medical Association that the AMA is also concerned that there will be a lowering of standards under this legislation. Proposed section 3(3) states that the guiding principles of the national registration and accreditation scheme are as follows. It then goes on to state in paragraph (c) that one of those guiding principles is —

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

I foreshadow that I will be moving an amendment to delete the words "are of an appropriate quality" and insert the words "are consistent with best practice guidelines". I have explained my experience of standards as a member of the Australian Nursing Federation. I have also discussed this with, as I have said, the AMA and the Medical Defence Association.

Dr K.D. Hames: Do you know that the AMA has been talking to me about that particular matter for six months? The people who recommended the change to that wording was the committee of the presidents of the medical colleges themselves. They are the ones who recommended that wording. They are of the belief, as is the president of the AMA, that that is equivalent to best practice.

Dr J.M. WOOLLARD: I do not know that the president of the AMA —

Dr K.D. Hames: It is not the president of the AMA, but the president of the medical boards.

Dr J.M. WOOLLARD: That is interesting, minister, because I actually met with the president of the AMA, I think yesterday —

Dr K.D. Hames: It was not that one.

Dr J.M. WOOLLARD: These are very senior and respected people. But how many of these people have been members of committees that have looked at standards and competencies?

Dr K.D. Hames: They are the presidents of the medical colleges.

Dr J.M. WOOLLARD: They may be the presidents of the medical colleges, minister, but how many of them have had that grassroots-level experience and have looked at standards and competencies? Initially, I thought that the words "appropriate quality" may be a higher standard at law than the words "best practice principles", but, when I checked this I was told that is not the case. I was told that legally it is believed that the highest

standard would be contained in the amendment that I intend to move, which is that health services are provided safely and are consistent with best practice principles.

The minister has said that this legislation is similar to the legislation in the other states. I draw the minister's attention to page 75 of the bill. The Queensland health practitioner legislation does not include Chinese medicine, medical radiation practice, occupational therapy —

Dr K.D. Hames: There is a simple explanation for that. That is that, subsequent to their original bill, it was decided by the medical council that those four professions will be included in the next phase. That is why we have got those four in there, ready for the next phase of registration, which is 2012.

Dr J.M. WOOLLARD: The minister has added these now, prior to that. There are grave concerns, particularly in relation to Chinese medicine. I will come back to that when we look at the terminology.

Dr K.D. Hames: Sure, but that is 2012. The other states will all be adding those same things to their legislation. They will. I am getting a nod from the adviser at the back of the room.

Dr J.M. WOOLLARD: It is hoped that between now and when that legislation comes through, certain titles that are currently in this legislation will be amended or deleted.

I turn now to proposed section 5 of the Health Practitioner Regulation National Law, at page 74 of the bill, and the definition of "external accreditation entity" —

> ***external accreditation entity*** means an entity, other than a committee established by a National Board, that exercises an accreditation function.

I foreshadow the following amendment —

> ***external accreditation entity*** means an accreditation entity recognised under the Health Insurance Act as of 1 July 2009, or, where such an entity did not exist, an entity other than a committee established by a national board that exercises an accreditation function.

I draw the minister's attention to schedule 4 of the Health Insurance Act. The minister has just said that this bill was supported by the heads of the medical colleges. This lists the specialties that those colleges have accepted.

Dr K.D. Hames: We have done that. The ministerial council ticked off on all those specialty classifications about three or four weeks ago. It did that independently of the bill. There is a list of all the specialties that have been classified.

Dr J.M. WOOLLARD: I would appreciate a copy of that list, because when we come a bit later to titles, I am actually going to discuss the title "family physician". I would appreciate it if, maybe during the dinner break this evening, I could look at that list before we move into consideration in detail.

Dr K.D. Hames: You were actually given a copy of this yesterday. Perhaps, in all your paperwork, it has been misplaced. I will get you another copy.

Dr J.M. WOOLLARD: I thank the minister for that. I am not sure that that is from the act that I was referring to—namely, the Health Insurance Act. I think that may differ.

Dr K.D. Hames: This is the list of specialty names that we have endorsed at the ministerial council, such as specialist paediatric cardiologist, and specialist physician.

Dr J.M. WOOLLARD: Minister, I did receive a copy of that list. But what is missing from that list, when we talk about physicians—this is something that we can talk about later when we move into consideration in detail—is that the AMA would like to protect the title "physician". One of the reasons they want to protect the title "physician" is that some general practitioners are known as "family physicians". That title does not appear on the list that is currently being copied. The physicians that the Minister for Health refers to on that list are acute physicians.

Dr K.D. Hames: So those GPs will not be allowed to call themselves family physicians, because it's not an endorsed title.

Dr J.M. WOOLLARD: That is why I am hoping that the minister will accept an amendment to the section in the act that has the term "medical" to include the term "physician" so that that title is retained for medical professions. There are no other professions that use that title and the Australian Medical Association would like to protect it for its members. One day, when the minister decides to move back to general practice, I will have protected his bread and butter! This is what the minister will go back to practise as! I hope he will support that amendment, because he may want to go back into that area and call himself a family physician.

As I said before, the great concern about this bill is that we will now have a ministerial council that will nominate a national board; at the moment it is the medical board. As emerged during the briefing yesterday, it seems that the national medical board will delegate powers to the state medical board. However, it will not be the state medical board that we have now.

Dr K.D. Hames: It may well be, because I will be appointing them, the same as I do now, so there's no reason it wouldn't be the same.

Dr J.M. WOOLLARD: I agree that the minister will appoint the board now, but just as the planning bill has unintended consequences—I am still hoping to change members' opinions on supporting that bill—this bill could also have unintended consequences.

MR J.R. QUIGLEY (Mindarie) [5.52 pm]: I rise to say a few brief words in support of the comments made by the member for Kwinana, but my real interest in getting to my feet this evening is to deal with the situation concerning psychologists, because I, too, have been lobbied by a friend of mine from Scarborough. Dr Ollie Kay was on the Psychologists Registration Board of Western Australia, as was his life partner, Dr Marjorie Collins, from Murdoch University. They are known to the minister, I believe. Both prevailed upon me to urge the importance of retaining in Western Australia the specialty of clinical psychologist.

For decades upon decades, and in all sorts of situations in life—from trauma to marital breakdown to general mental infirmity—the medical profession in Western Australia has referred people to clinical psychologists. Because of their speciality, they have received good recognition in Western Australia for being clinical psychologists and the additional training they undertake beyond the degree in psychology.

Dr K.D. Hames: I think they do about eight years and a masters degree on top of their normal psychology qualification.

Mr J.R. QUIGLEY: Yes. If the situation were to be left with the Psychologists Board being wiped out, the bill would have to come back to this chamber in due course.

Dr K.D. Hames: I raised this matter at the last ministerial council meeting two weeks ago and got agreement from all the ministers that the issue would be referred back to the Psychologists Board and the Physiotherapists Registration Board to ask them to reconsider that point, because I share the view that that specialty title should remain. Changing it in this state legislation will not make a difference because it is national legislation. Therein lies my problem; I need to convince ministers from other states that that is the best option. That is one critical area where you and the member for Alfred Cove are right; if we're talking about standards, that is the standard I think we should be maintaining.

Mr J.R. QUIGLEY: It has been put to me that simply not repealing the Psychologists Act would preserve the situation to allow this.

Dr K.D. Hames: The deputy leader put that view. I can't believe that it could be that simple, but I intend to ask during the break. I think that would leave them totally out in the cold; they may want to be left out in the cold, but I can assure you that not all of them do. There are a lot of psychologists who believe that a national system is by far the best system. It gives them freedom of movement and recognition of qualifications. There are some who believe that endorsement of that profession is the equivalent of calling it a specialist title, and it still requires them to do the eight years of study to be an endorsed clinical psychologist. You can't get that title without doing that number of years of study, but I will be asking during the break.

Mr J.R. QUIGLEY: If one came from the eastern states with lesser training, one could still achieve registration here.

Dr K.D. Hames: I don't think so for clinical psychologists; you need to be endorsed, and there are requirements to get to the endorsement to be a psychologist, although not the higher level of title that requires extra training. I am going to double-check on those things during the break.

Mr J.R. QUIGLEY: If it is as simple a matter as preserving the board, the minister might give some consideration to that.

Dr K.D. Hames: The difficulty is that there are lots of psychologists, not just the ones that are agitating for the change. I've been approached by others who don't agree and who think those high levels of qualification actually make it harder to get anyone to want to do it. As I've said, I do support having that level of clinical psychologist as a specialty and being a specialist position. I agree with that, but to get it in I have to get it through the federal legislation, if the alternative is not putting that through, and that's what all the psychologists want. I think that's a position that you'd have to come to between now and the other house, but I have to say that your federal colleagues would be extremely upset with you, not that that necessarily matters! The federal minister and your other federal colleagues are of the view that we need a national system across the whole of

Australia and that that is the best option, but they have agreed to reconsider that point. They agreed with me the other day to send it back to the board. Remember, it was the board of psychologists that made the recommendation to us to have areas of endorsement. It was not our decision. We've gone along with the decision of the national board, which is made up of psychologists from all over Australia, including our own. The difficulty was that our psychologists stood aside during the vote because they said they had a conflict of interest because they were clinical psychologists.

Mr R.H. Cook: It's not a conflict of interest.

Dr K.D. Hames: I don't think so either; I'm disappointed they stepped out.

Mr J.R. QUIGLEY: They believed they had a conflict because they were already clinical psychologists and that would be self-serving. I do not see that as a conflict at all, but that train has already left the platform.

Dr K.D. Hames: Neither do I, and my views have been transmitted. It is an issue that we need to work through over the next couple of weeks.

Mr J.R. QUIGLEY: The minister will take some advice on that position over the dinner break. If we put that suggestion aside for a moment and return to what was put at the council of Australian health ministers, the issue was to come back to that council.

Dr K.D. Hames: Yes; we were to go back to the board, ask it to reconsider and to make a recommendation back to the ministers again. At the end of the day, those specialist categories are still our decision as ministers.

Mr J.R. QUIGLEY: Are there any other states with this issue?

Dr K.D. Hames: No, none of the other states has that; we're the only one.

Mr J.R. QUIGLEY: Would the minister see that as a diminution of their standing here?

Dr K.D. Hames: I do, so any assistance you can give in talking to other state ministers for health would be appreciated!

Mr J.R. QUIGLEY: I will leave that to my colleague the member for Kwinana, who might be able to lobby in that regard.

Sitting suspended from 6.00 to 7.01 pm

Mr J.R. QUIGLEY: Mr Speaker, I was having an across-the-chamber discourse with the Minister for Health before you took the Chair on the proposition that has been put before me by those who have sought to lobby me for the preservation of the specialty of the clinical psychologist and who advanced the suggestion that if we excised from this legislation that is now before the chamber the repeal of the Psychologists Board and let that stand, the situation of the clinical psychologist would then be preserved. The minister was going to make some inquiries about that over the dinner break. He might be gracious enough to inform the chamber of his inquiries.

Dr K.D. Hames: I found out a couple of things. One is with regard to the question of not revoking the current psychology board establishment act and what that would do. My advice is that it would cause extreme disruption, largely because the clinical psychologists are not the only psychologists in town. There are lots of other types of psychologists, as we discussed earlier. I still do not know the split. There are people who do a standard psychology degree and then some who do a higher level. All of those, whether they wanted to or not, would be split away as a result of this.

Mr J.R. QUIGLEY: And therefore would not come under the national registration.

Dr K.D. Hames: Yes, unless we changed that later, if we could. That would be difficult in itself. I have here from the Psychology Board of Australia the areas of endorsement of registration standard. It talks about the standard that you need to be registered as a psychologist. They require significant levels of degree. Having said all that, I still support the proposal that the state psychologists have put forward. That is why the national board has decided you do not really need to call them a specialist because this endorsement is the same thing. If you are endorsed as a clinical psychologist, you have to have undergone the same level of training that Western Australian psychologists do. You are not dumbing down Western Australia. On the other side of the coin, if it makes no difference, why not call them specialists, as we do here in Western Australia? Why not have that as part of the national standard that lifts everyone else to do that? That is still the proposal I intend to follow. It needs to be changed under national law. As I have said, I have asked the others to reconsider and then I have to obviously convince the ministers that that point of view is the correct one. If I don't, the psychologists don't have a win, I guess, because it becomes national law and then it is too late. The alternative to totally take all of those psychologists out of the system is an extreme way to try to solve our state problem.

Mr J.R. QUIGLEY: That is about as far as I can take it this evening on the second reading. I will take that on board and go back to those who have been lobbying me. Perhaps I will make some further comments in consideration in detail or the third reading debate. I will conclude my remarks at this point and let others rise. I thank the minister for the inquiries he made over the dinner break.

MS L.L. BAKER (Maylands) [7.05 pm]: I have some similar issues that constituents have brought to me. If there is some information that the minister can add or clarify during my speech, he should feel free to do so. Concerns about the Health Practitioner Regulation National Law (WA) Bill 2010 have been raised with me, one in particular by Shelley Farrow, a registered psychologist and member of the Australian Psychological Society. While she is not a community or health psychologist, she wrote a letter in support of the two parts of the psychology disciplines which have been omitted from the national registration and accreditation scheme for psychologists and which come into force on 1 July. They are not recognised as specialists, according to my constituent, and she is very concerned about that. I wanted to get on the record what role these two parts of psychology play because they are fairly new when we look at the profession of psychology. I am quite familiar with this, as I have a psychology degree. Way back in the dark ages when I did mine, there were only three or four streams and now there are nine, including neuropsychology, clinical, counselling, educational and development, organisational psychology—that was there when I studied—sports and exercise, forensic, and health and community psychology. I thought it was worthwhile having a conversation about what these specific areas of the discipline actually do. Before I do that, I would like to say that it seems that the Australian Psychological Society and the Psychology Board of Australia were both supportive of community and health psychologists becoming specialists under this new accreditation system.

Dr K.D. Hames: Nine were put to them and they supported seven. This is the list that I have of the ones that they have supported, so we haven't changed what they recommended to us.

Ms L.L. BAKER: That is interesting. I will have to go back and seek some further clarification before the third reading. My constituent understood that the Australian Health Workforce Ministerial Council endorsed only the seven, and she is quite right about that, but the Psychology Board of Australia put more forward. The World Health Organization has also recognised these roles of community and health psychology as improving social, environmental and community determinants in one's health outcomes and is urging governments around the world to move beyond medical perspectives of ill-health that currently underline a lot of health policy.

I would like to quickly describe the two areas of specialisation. The first one, community psychology, deals with the relationships of the individual to communities and the wider society. I ask members to forgive me if I read some of the specific details.

Dr K.D. Hames: That would be good because I'll be sending a copy of what you say to the Psychology Board—the national board.

Ms L.L. BAKER: That is excellent. I thank the minister. I quote —

> Community psychology makes use of various perspectives within and outside of psychology to address issues of communities, the relationships within them, and people's attitudes about them.
>
> …
>
> Closely related disciplines include social psychology, political science, sociology, social work, and community development.

The Australian Psychological Society states —

> Community psychologists have specific training and experience in understanding and supporting communities of people, and individuals within communities, as they face various challenges to their physical and mental wellbeing, such as drought, unemployment, violence and poverty.

They worked during the Victorian bushfires to help the survivors of those bushfires. That is a good example of the kind of role community psychologists play. It continues —

> They work with identifying and facilitating the strengths and competencies of community members, from elected leaders to grass-roots organisers and groups. They recognise human differences and diversity within community contexts. To address this, they are committed to processes that support flexibility, equity and respect for cultural diversity in meeting the needs of different communities. Community psychologists work as consultants in partnership with groups, organisations and residential communities to achieve their respective goals … to solve problems and to prevent or reduce threats to individual and collective wellbeing, to promote social connectedness, and to facilitate the engagement or re-engagement with community of marginalised individuals and groups.

A lot of the social inclusion agenda has been picked up and implemented by community psychologists who work across our country. The website continues by outlining that community psychologists specialise in —

- Needs analysis for communities at risk, such as immigrant groups and rural and remote communities
- Community asset mapping of social capital and related resources
- Community generated problem solving based on collaboration and social justice
- Community capacity building to manage change and address risks and threats
- Evaluation of psychosocial environments with respect to sense of community, quality of life, social support networks, resilience, etc
- Social impact assessment related to environmental issues such as drought and climate change.

I will not go through the current qualifications and registrations, because when this information was posted by the Australian Psychological Society on its website, it was clearly anticipating this new arrangement, as it states —

> As of 2010, they will be required to be registered with the Psychology Board of Australia. This is to ensure that they meet specified standards of competence and ethical practice.

It goes on to talk about the various accreditation, qualifications and registration requirements.

I will move now to talk about health psychologists and about the work these practitioners might do. I know the minister is very keen for this sort of work to be done in Indigenous communities. Health psychologists will be at the forefront of work in these areas. Health psychologists are specialists in health behaviour change, so I think places like Healthway might attract this type of person. They have health promotion experience and understand how to change behaviour around health. The website states —

> Health psychology investigates the links between psychological and social factors, and physical health in order to improve health and prevent illness.
>
> Health psychologists practise in two main areas — health promotion and clinical health psychology. Health promotion involves the prevention of illness and the promotion of health-related behaviours.

I will talk a bit about both those areas in a minute. The website continues —

> Clinical health psychology involves the application of psychological principles to the assessment and treatment of illness, and to rehabilitation.

Talking about health promotion for a minute, the website states —

- This field aims to promote positive health behaviours and reduce harmful health behaviours such as poor dietary habits, smoking, alcohol and other drug abuse, and physical inactivity.

They are very concerned about behaviours like smoking and obesity. It continues —

- It aims to reduce risk factors associated with chronic conditions such as obesity, heart disease, diabetes, stroke, cancer and injuries.
- Health psychologists work with other health professionals and advise on attitudes, beliefs and behaviours that contribute to ill health, and how they might be changed (e.g., programs to assist people who overeat or eat a high fat diet).
- Health psychologists design public health programs in areas such as behaviour change related to exercise, alcohol, cigarettes, drug consumption, and injury and cancer prevention (e.g., ‘SunSmart’, ‘Life. Be in it’).
- Health psychologists work with community members and professionals to improve health and wellbeing by estimating the distribution of disease, health behaviour and modifiable determinants.

Population health might be another place that will need health psychologists who are well qualified and recognised for their qualifications.

Finally, the website outlines clinical health psychology, stating —

- Health psychologists specialise in developing education and behaviour change programs to help people to recover from or self-manage chronic illness, trauma or disability.

- Psychological treatments also reduce problems that can accompany and contribute to illness and injury, such as chronic pain, addiction, poor sleep, eating problems, anxiety, depression and emotional reactions such as anger and grief.
- Health psychologists help people to cope with the diagnosis and medical treatment of acute health problems and to obtain medical care.
- Health psychologists assist people to cope with terminal illness, including the impact of loss, bereavement, death and dying.
- Health psychologists design and test interventions to improve health systems and relationships between health professionals, doctors, nurses and psychologists, and monitor impacts on health determinants that encourage recovery from illness and injury.

These are clearly two very important areas, particularly in Western Australia but also all over Australia. Indigenous health in Western Australia has been addressed in numerous reports, such as the Reid report, which pointed to the major inequities in health status and access to health care for Indigenous Western Australians. On 16 March 2010, the minister announced the $128.7 million reform program under the Council of Australian Governments national partnership agreement to improve Indigenous health over the next four years. I mention these things because when I looked at some of the work that is being done in Indigenous communities, it was very clear to me that the role of health and community psychologists would be vital in these areas. For instance, Indigenous health workers help to set up social support networks. Programs include the breakfast programs that are run in schools, the fringe dweller support program and sobering-up centres. Those types of programs are the ideal place for well-trained and well-qualified community and health psychologists to work. They would work to make sure that fresh food is available through these programs. They would run programs in Indigenous communities to help reduce the incidence of diabetes and improve the overall health of Indigenous Australians. As I referred to earlier, they would also assist with rolling out alcohol accords and bans. I refer to those specific instances to, I suppose, make a plea for these initiatives, which are relevant to health activities in this state and certainly help to manage chronic disease, develop social support networks and help with community resilience. These psychologists play an important role in the prevention of family violence, which is particularly crucial to women but also to some men's wellbeing. Using the principles of equity and respect for diversity, these psychologists establish strong links with Indigenous and other community groups who have typically lacked access to mainstream health services.

It would be a very negative outcome if this bill were passed without due recognition being given to community psychologists and health psychologists. To deny recognition to these two prominent areas in psychological practice would put the community at risk from practitioners who might hold themselves out to be specialists but who do not have the advanced skills and knowledge required to competently fulfil specialist roles currently filled by community and health specialists. I urge the minister to continue to lobby on this matter. We can hopefully come back and talk about amendments at some point.

MR C.J. TALLENTIRE (Gosnells) [7.18 pm]: I will make a brief contribution to this debate on the Health Practitioner Regulation National Law (WA) Bill 2010. It is important to say from the outset that the community gives quite substantial weight to registers of health professionals. People expect good quality in the management of registers, whether at a state or national level. There is also a case to be made for a national register that enables professionals to move from one state to another with ease, and for the quick recognition of their qualifications. That is also useful in an international context. I am sure when health practitioners have a qualification that they can present to show that they are registered with a board in one state, that is good, but it would be even better when they want to work overseas if they can present their qualifications as being recognised and leading to their registration on a national register.

Broadly, there are some good things in the bill, but I want to raise a couple of issues on behalf of constituents who have contacted me about this legislation. The first relates to the situation with physiotherapists. I suppose it is the case with all specialists, whether they are medical specialists or health specialists, that they are people who have put an enormous amount of time and effort into developing their specialisation, to gaining recognition from their peers, to becoming members of professional bodies and to being recognised as specialists. We have to enable those people to continue to promote themselves as specialists with particular qualifications. We are all beneficiaries of that system when we need specialist treatment and we can go to a person who is a recognised specialist in a particular area. That no doubt aids our recovery and gives us confidence in the system. It enables us to feel that we really are dealing with the best-qualified person in a particular area. That is vital. On the one occasion that I have had need for specialist treatment, it was very useful to know that one of the best people in the area was treating me.

One of my constituents who works in the physiotherapy area has requested that I detail her circumstances to the minister. She is Jacqueline Ancliffe and she works as a specialist neurological physiotherapist at Royal Perth Hospital. Her actual title is senior physiotherapist neurosciences. Jacqueline has advised that she is responsible for the physiotherapy management and treatment of all patients with neurological conditions at the Wellington Street campus. She says —

> While I am directly responsible for patients on the Stroke Unit and Neurology ward, I particularly advise on the physiotherapy treatment of neurological patients in the Intensive care unit, oncology, trauma unit and medical wards at the request of my colleagues and senior medical staff. Senior and junior physiotherapists from other metro and country hospitals regularly contact me for advice on treatment approaches, current and updated evidence for treatment and with requests for assistance in the education of staff and students, to ensure the best possible outcome for their neurological patients in WA.

Jacqueline is concerned that her specialisation will not be recognised as we move to this new regime. She details further that last year at the urging of her titled neurological physiotherapy colleagues and senior medical staff, she undertook and was successful in passing the specialisation examination conducted by the Australian College of Physiotherapists. She is the only specialist neurological physiotherapist in Western Australia and one of only five in Australia. It is clear that Jacqueline has special qualifications and deserves the recognition that goes with that, and, I would like to think, she also deserves the remuneration that goes with her degree of specialisation. She goes on to say —

> The specialist title recognises a level of knowledge and advanced training in my area of neurology which can only benefit the public, patients, colleagues and administrators. It acknowledges a level of expertise and allows the public access to the best practice my profession can provide in neurology. It provides a clinical career pathway for physiotherapists in both public and private sectors and should assist in the retention of physiotherapy staff in the public health system. The future indicates an aging workforce and an aging population with increasing complex rehabilitation needs. It is recognised that physiotherapists will have a key role to play in the management of their rehabilitation needs. With no specialist physiotherapists there will be no access to specialised treatment for patients with complex and catastrophic conditions and the potential for poorer outcomes will lead to increased costs and increased length of stay.

On that basis, Jacqueline makes her plea to the minister that we support the national registration of specialist physiotherapists, and that the minister uses his powers to ensure that this specialist recognition is part of our national registration system. Jacqueline has very well made the case that we have to ensure that individual specialisations are fully recognised and appreciated.

Turning now to the area of psychology and those professionals working as psychologists, I have another constituent, Marie Hardman, who is a clinical psychologist and a member of the Australian Psychological Society. She points out the importance of making sure that people who undertake various tests are properly qualified to do so. As a clinical psychologist, she points out that the people who are best qualified to do the administration and the interpretation of certain tests are trained clinical psychologists. In a letter to me she has pointed out some real dangers if the right people are not doing the job. She says —

> I hold serious concerns regarding the absence of restrictions on the conduct of psychological testing under the Scope of Practice provisions in the … draft of the *Health Practitioner Regulation National Law* ("Bill …"). The draft Bill must provide for restrictions on the use of psychological tests since a failure to restrict their use to professionals who are appropriately trained and qualified will expose the public to seriously poor practice. In the hands of untrained practitioners this may produce inaccurate assessments and analysis in the hands of people unqualified to administer and interpret them. The potentially devastating consequences are very real. They include the misdiagnosis of psychopathology and cognitive as well as intelligence and learning ability, unwarranted stigmatisation, misdirection of life planning, faulty personal perceptions and poor career advice. I believe that persons who use such instruments **must** be adequately trained to do so and the prospect of failing to ensure this is a concern as serious as free access to the prescription of medications and the consequent health risks which would ensue.

She says that only psychologists who are appropriately trained to administer such tests and accurately interpret them should be able to do that testing.

I have outlined two good examples of how this legislation has to be refined. I understand the need to ensure that it is in sync with what applies in other states. I appreciate that, but we have to ensure that the debate in this

Parliament leads to a quality of national legislation that will not only meet the needs of all Western Australians, but also will be improved by taking heed of those points made by my constituents.

I will conclude my remarks, but clearly some more work needs to be done on this legislation, and I look forward to hearing the minister's comments as we give further consideration to the legislation.

MR B.S. WYATT (Victoria Park) [7.29 pm]: The Health Practitioner Regulation National Law (WA) Bill 2010 certainly has some importance for very important professions in Western Australia. I am aware that this bill is being dealt with as a matter of urgency due to the fact that the federal government is keen to have a national regime in place for operation by 1 July 2010. The shadow Minister for Health, the member for Kwinana, has raised the opposition's concerns with the legislation. It is my understanding that the minister shares those concerns and has made some undertakings to the member for Kwinana that once this legislation is passed, he will continue to negotiate with other state health ministers to resolve those issues. I must say straight up that I understand the importance of, and the rationale behind, having uniform regulations for professions. I also understand the importance of removing red tape in respect of people plying their trade, for want of a better expression, around Australia. However, we also need to be careful that we do not have a rush to the bottom end in an effort to cut that tape or in seeking uniformity of legislation. It certainly seems to me from the correspondence and advice I have received from some clinical psychologists in my electorate that here in Western Australia we have a very good and well recognised regime for regulating and recognising clinical psychologists in particular that is international best practice. It is important that we in this house recognise that.

Although the opposition will vote in support of the legislation, we will move some amendments that no doubt the government will oppose. However, as I said, we in this house must acknowledge that we have a good regime under which our clinical psychologists are not only qualified but also recognised. We must protect that against the best interests of a federal government desirous of a uniform regime. The shadow Minister for Health, the member for Kwinana, will continue to pursue that with the Minister for Health. I am pleased to hear that the Minister for Health shares the opposition's concerns.

I will read an email I received from a constituent—a vaguely lengthy email of a page and a half in length. It will form the crux of the comments I want to make because I think it sets out in a much better way than I can exactly what are some clinical psychologists' concerns about this bill. I thank Trish Hart for her advice to me about this issue. I would not have got across this issue without her input and emails to me. She makes the point that, as a clinical psychologist and member of that community in Western Australia, and along with other specialist psychologists in Perth, she is very keen to not lose the standards under the WA registration that they have been able to maintain. They see that very much as a way to protect the public who access the clinical psychology profession. I will outline as follows some of the concerns that Trish raised with me —

> **1. It is alleged that the new Psychology Board of Australia submission to the Ministerial Council did not represent the views of the profession and due process has not been followed.**
>
> - Our profession was shocked and concerned when the Psychology Board of Australia (PBA) requested the Ministerial Council accept "area of practice endorsement" to identify the specialist training and skills for our profession. The consultation paper put to the profession in November 2009, supported **registration of specialist title** for representing the higher training of the profession. We know that 79% of the submissions from our professional community to the PBA which commented on specialist title, supported this position. So the PBA's final submission to the Ministers does not represent the will of the profession.

Obviously that is a core part of the concern of Trish and, I dare say, based on the petition that was read into the Parliament today by the Deputy Leader of the Opposition, a significant number—some 800-plus people—have with that very issue. To continue —

> - The option of "endorsement of area of practice" has not been presented to the profession for comment and feedback. This represents a serious flaw in the process.
> - The profession insists that the PBA now follows due process and asks for feedback about this option now, with the view that the PBA respond to the feedback and consider making revisions/changes to their proposal on the basis of this feedback.

I make the point now that this email was dated 9 February, so things may have happened since Trish emailed this issue.

Dr K.D. Hames: Not a great deal.

Mr B.S. WYATT: Okay. The second point in the email reads —

2. Endorsement of Area of Practice vs Registration of Specialist Title.

- A significant concern with "endorsement of area of practice" is that this is an administrative and discretionary function of a Board. Therefore definitions regarding endorsements, now and in the future, will depend on the membership of the Board, and influences the Board may come under, especially from Government or Government bodies.
- There is no protection in Law in the process of definition and regulation under endorsement, unlike registration of specialist title, where qualifications for specialist title are clearly defined and have the full force of the law to maintain these standards.
- Endorsement does not protect title in the same way, or to the same degree, as **registration** of specialist title. Under endorsement, when misuse of title occurs, the Board has to show that an "ethical breech" has occurred and then has to argue the case for this and try to enforce penalties. There is likely to be significant costs and time associated with administering penalties and possibly even proving the case. With the force of Law, as in the case of registration of specialist title, misuse of title is clear and penalties can be more easily and readily enforced.
- The definitions for endorsement are as yet to be made clear, which we understand will be discussed in March. However, there are already concerns that the PBA may not be able to hold the supervision aspect relating to specialist training (in WA currently 2 years in addition to a 6 year Masters degree), as it may be "beyond the Board's ability to monitor and may be too costly". ***If the compulsory post masters supervision component is lost, this would represent an erosion of the standards we currently have in WA which are the only standards currently meeting international training standards.***

That is the crux of some of Trish's concerns as well as the concerns of certain people who signed the petition that the Deputy Leader of the Opposition presented to the Parliament today; that is, in Western Australia protecting that compulsory post-masters requirement that meets international standards, which are much higher than the standards that this legislation we are debating tonight will impose. To continue —

> This would leave Australia in the position of not meeting international training standards at all, and we would remain the country with the lowest level of training for entry into professional psychology practice in the western world.

That is something that all members of Parliament should be concerned about. To continue —

- With our medical colleagues — who we rely on for referrals (and relate more to, rather than "allied health", especially in WA), the use of the term "specialist" represents trust, professionalism and collegial equality. There is real difference in those terms/words and there would be a negative effect of this aspect of our professional identity and standing.
- There is also a considerable potential that the highly trained and skilled workforce we currently have will be eroded over time. It could be envisaged that young people entering training in our profession will see no need to invest the time and significant costs associated in undertaking postgraduate training when they can practice in any area without endorsement. It also robs them of their professional identity which is essential in any skilled workforce area.

3. By removing specialist title for the Psychology profession the public will be at risk.

- Specialist title registration (which WA has had for over 30 years), **clearly identifies** highly trained professionals to the community and the medical profession.
- The community and medical profession understand the concept of 'specialist' and WA specialist psychologists have done extensive work with the community and medical profession to inform them of the level of training our specialists have. The degree of this understanding is highlighted in the Medicare statistics (2008) which showed that WA was the **only** state where there were nearly twice as many specialist services used when compared with generalist services. **In all other States the statistics were in reverse and then some.**
- The community does not understand the concept of "endorsement of area of practice" and they will get lost in the system trying to find highly trained people. We know from registration statistics that they will only have a one in seven change in the national arena of finding a specialist trained psychologist, due to the numbers of 4 year undergraduate psychologists.
- All of these factors place the public at great risk of not receiving a proper diagnosis and use of therapies they require.

4. Workforce concerns are not an argument against specialist title.

- The Government Mental Health Workforce Advisory Committee (2008) wrote a report regarding the supply of psychologists and they determined that there is no shortage of psychologists in the workforce at present, that numbers in the profession are increasing, but that further monitoring and analysis on the psychology labour force is warranted to monitor developments. There is no evidence of a shortage of specialists.
- In the last Budget of the Howard Government, workforce concerns raised at that time were addressed by increasing Federal funding to universities for funded places in postgraduate programs in Clinical Psychology. This could apply to other areas of psychology (e.g. Health Psychologists). We would support this type of solution to possible workforce issues.
- We are not aware that having specialist title registration for over 30 years of WA has had any negative impact on workforce numbers any different to that in other States.

The Eastern States need to look to the **long experience** of Western Australia with registration of specialist title and the benefits it has brought to the profession and the public. Wages and career pathways and the public sector in WA cannot be matched by any other state and, as previously mentioned, Medical statistics support the clear identification and willingness by the general public and referring medical specialists to utilize psychology specialists.

I received a similar email from a couple of other constituents and from Dr Wendy-Lynne Wolman, who sent me an email attaching the letter that she and I think a lot of people sent to the minister from the Australian Clinical Psychology Listserv—from Dr Judy Hyde—to the minister. It basically sets out the same issues in the email I received from Trish Hart that I just outlined. It certainly seems to me that the email that I received from Trish Hart sets out quite concisely and makes a very strong case as to why Western Australia in particular needs to cast a wary eye over this legislation. It is being dealt with by way of urgency with the support of the opposition due to the pressing time frame in which this national practitioner regulation law must be in place so that it is operating by 1 July 2010. However, as has been pointed out by Trish, specialist clinical psychologists have a number of significant concerns. I think it is only fair that we recognise, understand and support the fact that they want to protect their qualifications and titles and the recognition of their work. It is an eight-year process of study and work that they go through to be registered in Western Australia as a specialist clinical psychologist. It is always dangerous in our Federation when we allow the lesser standard to become the national standard, which I know both the Deputy Leader of the Opposition and the Minister for Health are concerned about. The Minister for Health will pursue that issue so that Western Australia can maintain the registration and acknowledgement of our trained clinical psychologists. Indeed, my experience as a lawyer in Western Australia and practising law in Sydney highlighted the fact that there are separate regulations and professions, and that a number of states have a much easier process for those professions. It happens. Lawyers get themselves admitted as solicitors or barristers, or both, in a particular jurisdiction, and then, through the mutual recognition act, find themselves recognised in other states without having to go through a rigorous process similar to the one we have in Western Australia.

I thank Trish Hart for the number of emails I have exchanged with her and for bringing this matter to my attention. As I said at the beginning of my comments, although I understand the need for national regulations in a Federation so that people can practise their profession or ply their trade across the country in a uniform way without excessive red tape and different rules, we must be careful, particularly in the area of the mental health of our citizens, that we do not adopt a rush-to-the-bottom approach by abandoning our very rigorous standards in Western Australia, which we now know are the only standards that meet international standards and which ought to be protected.

With those few words, I look forward, once this legislation is passed, to the Minister for Health continuing to pursue this matter with other health ministers. I hope that he does not put it further down the priority list once the legislation goes through the Western Australian Parliament and that it does not become an issue of lesser importance for his no doubt busy office. I know that the health minister will not do that because he has made a very strong commitment to the Deputy Leader of the Opposition that he will continue to pursue this matter with great vigour. Certainly, we on the opposition benches will ensure that the minister does not allow this matter to become an issue of secondary importance the further away we get from the operation of the national law.

MR A.J. WADDELL (Forrestfield) [7.45 pm]: I will speak briefly on the Health Practitioner Regulation National Law (WA) Bill 2010. I rise not to discuss some of the issues that previous speakers have raised; I think those issues have been well canvassed. However, I note that it is a shame that we are racing to pass a bill of this bulk—332 pages—with such speed.

Mr B.S. Wyatt interjected.

Mr A.J. WADDELL: Yes, we can go into detail.

It seems a shame that we are doing that merely to obtain a seat at the table of this national body to ensure that Western Australia's interests are reflected in the initial formation of this law. It seems to me that any body that is clearly designed to deliver a national system would be more than willing to be flexible in its timetable to ensure that it is in fact a truly national system.

My issues are more to do with the nature of the legislation. I took the time to read some of the debates in the other states that have passed the equivalent of this bill. I noted with some interest that those debates were far more vigorous than that which has been presented today. Normally, they were characterised by Labor governments presenting the legislation as the greatest thing since sliced bread and Liberal oppositions pointing out that it is the evil devil's spawn of Kevin Rudd. It is interesting to see that we have a different approach in Western Australia.

Dr K.D. Hames: That's because you're in opposition!

Mr A.J. WADDELL: Would the minister be opposing it if we were in government? That is an interesting perspective.

My concern is that we are adopting this legislation as mirror legislation. In effect, this legislation sits entirely within the Western Australian Parliament, as I understand it. We have just copied what has happened in the Queensland Parliament, whereas other states have adopted what has happened in the Queensland Parliament. That creates an immediate problem in my mind in the sense that, given that we have a national system, one must look at all legislation as a relatively fluid situation whereby there will be problems and amendments and it will change as circumstances change over time. This will reflect on us in the sense that whenever these problems occur, one presumes that there will be a national body and the ministers will get together and discuss them and bash out some sort of solution to those particular problems. That will ultimately be reflected in the Queensland legislation, which will automatically flow to the other jurisdictions but which will then need to come back to this place for us to mirror. As we do not necessarily know what the outcome of the Queensland debate will be, it is quite likely that we will need to sit behind the Queensland Parliament to some extent and wait to see the outcome before we can present an identical mirror match to this Parliament.

Dr K.D. Hames: That is the point; it gives us the choice.

Mr A.J. WADDELL: Precisely, yes.

Dr K.D. Hames: Rather than me being overruled in a ministerial council on something that we do not agree to as a state and having it just put through Queensland and then it automatically becomes law in every state, the reason we have the mirror is that we decide as a Parliament whether we will adopt those amendments.

Mr A.J. WADDELL: I applaud the minister for that because he is standing up for something most Western Australians would support; that is, some independence for Western Australia. But it will create problems at some point in time, particularly when we have election cycles that are not quite in sync. A Parliament may be prorogued in one jurisdiction or another and there could be, literally, a six to 12 month delay, depending on the nature of the election cycle, the nature of the legislative program and the willingness of the government to do something about this act—as it will then be—before we get around to altering it. Then, of course, we will be subject to the vagaries of what in fact happens during our debate. The government might put the bill into this place in a mirror image but by the time it passes through the other place it might be altered in some way. There is the potential for drift. Drift is what we could see occur over time as our bill begins to drift away from the national act. That will create problems. We will start moving away from a truly national system.

Dr K.D. Hames: It seems to me the member is arguing against what his side is intending to do; that is, move amendments.

Mr A.J. WADDELL: No; we will be moving amendments. I am really talking about the nature of this type of legislation and a genuine concern that I have about it. In my short time in this Parliament, I have seen a number of bills passed that have really been bills to enable national agreements and national legislation. One cannot help but be filled with dread that 15 years from now there will be very little left for the WA state Parliament to be dealing with, and the last one out will have to turn the lights out behind them! I do not think that is an expression of the will of the Western Australian people. We need to be very careful to avoid basically abrogating all our responsibilities and rights. The sovereignty of the Parliament is probably the key.

An issue that comes out of that is, of course, regulation; that is often where we put a lot of the "meat" on legislation these days. As I understand the bill, regulations need to be agreed to again at the ministerial council level. The regulations will be put through the Victorian Parliament where they will lay on the table, but then each

Parliament can raise any objections to those regulations through its review processes. Western Australia would be able to move a disallowance motion in the upper house to disallow those regulations. In the normal course of events, if we felt that a regulation was somewhat beyond the scope of the original act or simply was moving in a direction that this Parliament did not sit comfortably with, we could move a disallowance motion for that regulation. The difficulty under this legislation is that would not override the regulation. We would need to have the agreement of the majority of states before that regulation was disallowed. Even though we have mirror legislation and the right to amend our own legislation, we will bind ourselves through regulation, which we may or may not, depending on what other states do, have the right to override. That obviously creates an interesting power dynamic because if we decided that we would not agree to alter our legislation in a particular way, one could imagine the other states getting together and doing something very similar to what this government has done on retail trading, which is to move beyond the scope of the original act and try to achieve something through regulation. In that case we are bound to that situation. There is no doubt that even though we have adopted a mirror process here, we are losing some element of sovereignty of our Parliament. That may be a price we are prepared to pay to be part of a national system. That may be something that sits quite comfortably with us. No doubt, as the debate unravels over the coming hours, we will determine whether that is the case.

Another interesting thing of note in this legislation is that it covers areas that are currently not regulated in Western Australia, such as the registration of Chinese herbalists from 2012. I am not aware of how many Chinese herbalists operate in Western Australia. It raises the interesting possibility that later on down the track regulations for areas that we have not contemplated could get caught up in these national schemes.

I was recently contacted by a constituent about a therapist, for want of a better word, who was operating without a licence; it was just an individual. I think it was a Mr Meinck. He was on the *Four Corners* program recently. That individual was wreaking a fair amount of havoc on a number of people. My constituent was concerned about how this could go on. That is a question I am still trying to unravel. It will be interesting to see how, when we are tied into a national system, we can deal with minor local issues that blow up. Would we need to step outside the national framework and create another act that sits alongside it to regulate a particular portion of the population, as opposed to what has been agreed nationally, because it is not an issue there; or will the opposite occur and we will be caught up dealing with a problem that has blown up only in Queensland? Let us say, for instance, that Queensland tried to deal with homeopathy, which is something I personally would outlaw as the quackery that it is —

Mr R.H. Cook: Don't hold back!

Mr P.C. Tinley interjected.

Mr A.J. WADDELL: They believe all sorts of strange things, so I would not be counting on their votes anyhow!

Dr K.D. Hames: What about the iridologists?

Mr A.J. WADDELL: It may be that Queensland tries to regulate that. I would be vehemently opposed to the idea of Western Australia registering anybody who practised homeopathy simply because I think the practice would then be given credibility that it does not deserve. The science on that practice is fairly well demonstrated as being, as I said, the quackery that it is. It would be a shame if we were bound to a situation like that.

They are the comments I wish to make. Members should think about the structure of the legislation, the nature of mirror legislation and how we will cope with the regulatory situation that will arise from it. The legislation will essentially invest a great deal of power in the minister, because the minister becomes the sole person who can make representations to the ministerial council. We will find that the people we represent will become quite distant from the process. It really is an obfuscation process. As things stand today, people would argue that our processes of government are very complicated. This is complicated squared in the sense that it passes through multiple Parliaments—regulations through one and an act through another. We have the mirror legislation. Changes can only occur if the majority of states agree. It is like having a federal referendum in order to overrule a regulation. The ministers will no doubt meet in private to discuss these things. Our ability to have direct input into a lot of these issues will be quite distant from the process. Our constituents therefore will be even more distant from the process. That is not a direction I would like to see all legislation take, but, as I said, under the circumstances it may be a necessary evil.

DR K.D. HAMES (Dawesville — Minister for Health) [7.59 pm] — in reply: I thank all those members who have made a contribution to this legislation. I would like to start by talking about the comments made by the Deputy Leader of the Opposition, which were largely, "If it ain't broke, why fix it?", and, "What's wrong with the situation that we have?" There is a lot of merit in those comments. I spent four years in opposition, during which time the former Minister for Health introduced the legislation to create all the boards for those individual

professions. Boards of equal stature and construction were created. When in opposition, we supported the passage of the legislation to create those state boards. We did not quite get through them all as the two left had not made it all the way through. When I became the Minister for Health, I found that a Council of Australian Governments agreement had been signed between former Premier Carpenter and the other state Premiers and heads of the territories that would throw that system out the window and move us into a national registration system. Moreover, I found that all the health ministers had agreed to what that legislation would be and how it would be constructed. They had agreed that the boards and committees would be based in Canberra. I saw that as a federal takeover and another massive Canberra bureaucracy. The support agency was to oversee all the national boards so it could give direction. There would be no independent requirement for the accreditation bodies. The state boards were to be scrapped. The previous Minister for Health was ready to sign off on the things that had been agreed to under that agreement when I became the Minister for Health. I told them that Western Australia would not participate in a national registration system under that construction. I was lobbied by many bodies, including the Australian Medical Association. It pointed out all the flaws and said we should not follow that system for a pile of reasons—reasons that I supported. I was caught between a rock and a hard place. As a state, Western Australia had agreed to the COAG agreement. Sure, new governments can always overturn COAG agreements, but that is tough to do. We need continuity in what a state agrees to. I had support from the boards of all 10 professions that supported moving to a national registration scheme. The reason they did so was similar to the points outlined in the comments of the member for Victoria Park. Although there was mutual recognition across the whole of Australia, there was inconsistency in the standards that people were required to meet to be part of a certain profession. Similar to what the member for Victoria Park said, other states could have lesser standards. We have mutual recognition in Western Australia so that other professionals can practise in their profession in Western Australia. It was generally agreed that there should be a national system. If a person is registered in one state, even under mutual recognition he has to specifically register in another state. I worked for a short time in Queensland. I had to register in Queensland. I did that two years in a row for four weeks at a time. I had to pay the full registration fee, and when I finished after four weeks I had to claim back the remainder of that registration fee from the Queensland system. That is obviously not the best system. We agreed that we would proceed with a national registration system that everyone supported, but we noted the concerns that everyone had expressed.

I set about putting forward a package that made major changes to what had been proposed. For a start, I suggested that the agency would sit beside and below the state–national board and that it should not sit above it. We agreed that after time it would move from Canberra to Victoria. This is not an area for the federal government; it is an area for state governments. All the states, with the support of the federal government—in fact with the initiation of the federal government through the COAG process—wanted to follow this process. I said that the agency had to change its position.

I will outline the agreed composition of the national boards. There were to be two doctors on the national medical board, plus the same sort of construction we have in this state for our state boards. There were to be a couple of doctors, consumer representatives, a lawyer and an accountant—the types of people who would make up a standard board. That would mean that each profession would have only two people on that board from the whole of Australia. The chances of us in Western Australia having anyone on any of those boards was remote. We may have been lucky to get a doctor on one board and an osteopath on another board. We may have been lucky to get four or five people on the total constructions of the boards, but that would be it. We would have had one voice on all those boards. I said that that was not acceptable. I said that we wanted our own doctor on the medical board and our own physiotherapist on the physios' board and so on and so forth. That was agreed to. The large states have a representative on the boards. The territories, with much smaller systems, were happy that their representatives would be the consumer representatives on the boards. I made the point that we did not need people on the national board making decisions about national registration; rather, we needed them on the state board that deals with complaints and issues on a state level. It is there that we want the participation. This was the case not only with doctors and physios; we wanted a range of professions involved on a state level to deal with complaints and disciplinary procedures. That was the next change we asked for.

The second key issue was the independence of accreditation, especially for medical services. We wanted there to be no interference from government or national boards on what an independent accreditation agency should set up as the requirements for the training of doctors, nurses, physiotherapists et cetera. We wanted that to be independent of the national boards. That was not needed with them all. In the end, we went for those areas that already had an independent accreditation body, particularly in medicine. Some, particularly the new ones, do not need that. The national boards will have a panel that will decide on those matters of accreditation. We wanted that independence. The only caveat was a wish for the ministers and the national board to have some direction. If, for example, the medical accreditation board suddenly decided that medicine should be a 10-year course, the national body would suddenly have no doctors for four years and we would experience severe workforce issues.

Alternatively, if it decided that medicine should be a three-year course, the opposite would happen and there would be a surge of doctors. We wanted some ability for the ministers to say that certain things are not acceptable or reasonable. The requirement is that the ministerial council can direct accreditation bodies on issues of accreditation if it has a major effect on the national workforce.

When I was arguing the case that the boards must be totally independent, the New South Wales health minister asked me a question: what would happen if, for example, a group of podiatrists suddenly decided to accredit themselves to do hip surgery and there was no power of direction or no power for the minister to say that that is not reasonable and that hip surgery is to be done only by orthopaedic surgeons? We have to have a power that will allow the ministerial council to direct.

The other issue was state boards. Under the initial proposal, state boards were going to become state committees and lose a lot of their powers. They were to be managed by the national board. We argued very strongly that the state boards should remain state boards and that they should have the ability to deal with issues of complaints and disciplinary procedures. I made it clear that Western Australia was very happy with the way its board operated, particularly the medical professions, and that they should continue to operate independently. The difficulty in having all this legislation drawn up in another state and agreed to by a collection of ministers in the east—the Labor ministers tended to get together much more often, particularly because Western Australia is a long way away from the eastern states—is that some of the provisions did not come through the wash in the exact way that we had agreed to them. I made it very clear at those early meetings that Western Australia would retain its independence when dealing with complaints and disciplinary procedures for the majority of matters. Once I suggested alternative positions and once I received the support of the other ministers, New South Wales, having agreed in the first place to go along with the rest of the legislation, decided it was such a good idea that it would buy the bank. Its complaints and disciplinary process is totally different from every other state's complaints and disciplinary processes.

It is like our Health Consumers' Council having total management, rather than the boards themselves, with independent tribunals, appeal mechanisms and a range of things. I have to say that every other minister and every other member of the medical profession in no way wanted that system. New South Wales tried to convince us all to adopt it as the national system. Every other minister and board member said no way were they going to do that but that New South Wales could keep its system. Because I was going to make sure that we kept our system, the board let New South Wales keep its system. In fact, because the New South Wales system is much more costly, members of the medical profession in New South Wales pay additional registration fees and that money goes directly to support their complaints and disciplinary procedures. But in the wash, we in Western Australia lost out on the legislation saying that Western Australia would have its own independence. As a result of that, I have since written to the board members and said to them that that is what we want. One of my options is to get other ministers to agree that if that is what we want, that is what we should have. However, I said in the interim that I would like from the board a commitment that the Medical Board of Western Australia will continue to be able to deal with its complaints and disciplinary procedures and a written guarantee that if ever it proposed to change that, the proposal would go firstly to the Ministerial Council of Health Ministers for a decision. The board has given me that letter of commitment.

Mr R.H. Cook: Will a change to the delegation always come back to the minister?

Dr K.D. HAMES: It will. If the board wants to change the delegation, it will always come back. I have to say, though, that it is not its intent to do that at all. Although I want that locked away so that no future body can change its mind, it is the board's intent that Western Australia continues to act as it is now. Remember that these boards are not federal bodies. They are not groups of people who know nothing about the profession. The national Medical Board of Australia comprises doctors from each state of Australia who make decisions about doctors in each state. It is the same with nurses and with physiotherapists; they make decisions about their own profession in each state and say what they want and how they should do that. I therefore intend to continue to work along those lines, but it would be better to have it locked in place.

Dr J.M. Woollard interjected.

Dr K.D. HAMES: I had a commitment from all the ministers early in the piece that that was what we wanted and that that was what we were going to do. I therefore do not anticipate having that difficulty.

Did the member for Alfred Cove want to interject?

Dr J.M. WOOLLARD: Under the guiding principles of the bill, the ministerial council can in fact appoint another body between the ministerial council and the national board. That is why I was referring to the unintended consequences. Yes, you have a commitment now, but that commitment will not last.

Dr K.D. HAMES: I was anticipating a brief interjection from the member for Alfred Cove, but things like that are to do with the detail of the legislation. I am making a response to the comments that members made.

Having put those changes in place, I have to say that our state got a lot of compliments from all the other ministers of all the other states, and particularly from members of the Australian Medical Association in other states, about what a great job we had done changing the legislation and putting it into an acceptable format. It was not going to get through the Parliaments of Australia the way it was. I can tell members that there would have been a great deal of strong opposition. There are upper houses in some states where the Liberal Party has the numbers and they would have blocked that legislation. That is why it got through the state Parliaments. Whatever the arguments were, in the end the legislation got through in every state other than the two that had elections, and it is strongly anticipated that they will get their legislation through in the near future. In fact, some Parliaments just passed in a day the template legislation that members talked about; they just passed it to get it all through.

That brings me to the speed of getting this legislation into Parliament and the little time members have had to deal with it. It appears to be speedy only because I have moved this urgent motion. Instead of getting the legislation into Parliament two weeks before Parliament adjourned, I got it in during the last week that we sat; otherwise I would have had to wait until next week to bring it in without having to move that it be declared urgent. I have therefore got it in one week early. That does not change the time in which members have to debate it.

Members must bear in mind that the legislation we are mirroring was enacted in Queensland a year ago. I will go through the consultation process that has been undertaken since that legislation was introduced. It will take me a little while, as there is a huge amount of it.

Mr R.H. Cook: We will need a couple of breaks for it!

Dr K.D. HAMES: So will I!

The first policy consultation papers on bill B were released between 28 July 2008 and 22 January 2009. On 28 July a public consultation paper on the partially regulated professions called for submissions. A public consultation paper on proposed registration arrangements was issued on 18 September—so that is a year and a half ago—and there were 108 submissions in response. Another consultation paper published on 7 October 2008—not 2009, but 2008—was about proposed complaints arrangements, which had 114 submissions. Proposed arrangements for information sharing on privacy, published on 5 November 2008, had 69 submissions. A paper on proposed arrangements for accreditation, released on 6 November 2008, had 73 submissions. Another one published on 13 November 2008 on other matters for inclusion in bill B had 50 submissions. A consultation paper of 22 January 2009 on proposed arrangements for specialists had 52 submissions. There were 500 written submissions received in total on the seven consultation papers.

Then there were national forums. One forum was on 28 October 2008. There were other forums on 18 November 2008—one in Melbourne and one in Sydney; a long way from here. Then there was the release of the exposure draft national law. Therefore, the first release of the legislation on the final national law was released in June 2009 with a call for submissions, which resulted in 550 submissions. They were in effect the modifications that were proposed to delay the first bill introduced to get all the detail of what was contained in the legislation. People who had therefore been involved in this issue and wanted to know the information proposed and the way the legislation was being planned had in fact from that time to see what the legislation was. Then there were many other forums in each state. I attended one in Western Australia, which was held in Floreat. There were meetings with peak representative organisations including the professional reference group on national registration and accreditation; the boards and registrars from the 10 health professions; the former Australian health professions council; a representative of the accreditation authorities and related health professions; the head of the health professions tribunals from most jurisdictions; health regulatory authorities of New Zealand; the joint medical boards advisory council; and so on.

There was therefore a huge amount of discussion across Australia about the contents of the bill. Rather than this being a speedy process, it has been a very long, tortuous and difficult process. I have to say that we had significant changes made to those early draft recommendations, largely based on the work of some of our professional bodies here in Western Australia, particularly the Medical Board of Western Australia. Pamela Malcolm spent a huge amount of time over east, where the members of the national body were drafting this legislation, going through the recommendations from Western Australia and getting significant changes. Therefore, all those issues that were still in bill B when it came to us underwent lots of changes to get it to this final draft based on what was there. So, having gone through all the turmoil of "we want this, we want that and

we won't do it unless", we finally got pretty well what we wanted. It is not 100 per cent; not everything that we wanted is in there, but the end result was a huge turnaround from where we had started.

I have to say that it is our fault that we are a bit late. This legislation was finalised towards the end of last year, so we have had from then right through until now to get this document into the party room. However, as I said, there were issues to do with the drafting over which I had little control that led to it taking a lot more time than we planned to get it into Parliament; hence it being so close to the date. Members have asked: what happens if we do not get there? They are right: there is a fallback position in October. I discussed this at the ministerial council meeting, particularly in front of all the ministers, saying that we were having trouble and that it was our fault that the timing was bad.

The federal Minister for Health and Ageing, Hon Nicola Roxon, MP, was quite critical. She said that we had had the Health Practitioner Regulation National Law (WA) Bill 2010 since November of last year and asked why we were so late getting it in. She said she had had a commitment from all the other states and territories to get this through and that we were the ones lagging with this—that was me. It is not the opposition's fault; it is my fault. I asked if there was a fallback position, because I had been told that, because South Australia and Tasmania had had elections, they might not have been able to get their legislation through. The response I got was that those other states thought they could get it through in time. Because the elections were over and the same parties had been re-elected to power, they were of the view that they could get it through. We were told that it would create problems if the legislation was not passed at the same time in all states and territories. I think the problems are not as great as the federal minister might be saying in that if we do not get the legislation through at that time, the state boards can send out the registration forms, as the member for Alfred Cove said, and people can still register at a state level. But, come October, those people will have to go through the process of transferring their registration over to the national system. That can be done, and the view is that it is fairly difficult but not impossible by any means. It would have to happen—there would be no other choice—but that is not an ideal situation. If we are able to get the legislation through, that will be the best outcome for Western Australia and for all our boards. If we cannot, so be it. We cannot control individually what the Parliament decides to do with its legislation.

I responded to some of the member for Kwinana's comments about ceding our powers to the federal government, which he accepted. The federal minister has been strongly supportive of a national registration system, as have we all. She certainly does not dominate the outcome of what the legislation contains. In fact, the Victorian Minister for Health, Daniel Andrews, MP, is one of the strongest personalities in that, and he has probably done the most work in making sure that the legislation goes through.

We then get down to some of the minor issues that are still a needlepoint for a lot of us. I will go through the Australian Medical Association issues, but I will do that only briefly because I am sure we will deal with those matters when we get to the amendments. The list that the member for Alfred Cove went through matches exactly the list I have been debating with the AMA for the past three months. We need to realise, of course, that the issue of psychologist and physiotherapist is not, in itself, in the legislation in terms of deciding specialties. When I look at the areas of endorsed specialist titles that cannot be used under proposed section 115, I see very few that are in the legislation.

Mr R.H. Cook: So long as it does not have the word "physician".

Dr K.D. HAMES: No, it does not. Proposed section 115 states —

> A person must not knowingly or recklessly take or use —
>
> (a) the title "dental specialist" … or
>
> (b) the title "medical specialist" …

It deals only with those two. Although acupuncturist comes in at a later point, the key ones that are named are those two. Proposed section 115(1)(c) states —

> a specialist title for a recognised specialty unless the person is registered under this Law in the specialty.

That brings us back to the list that I gave the member a copy of, which is the list of specialties, field of specialty practice and related specialties to which proposed section 115(1)(c) relates. Page 151 of the bill states that the fine in the case of an individual not adhering to the legislation is $30 000; and for a body corporate it is $60 000. People who say there are no penalties in the legislation for people who use terms they are not allowed to in

declaring themselves to be of a particular profession are wrong—the fines are very high. That covers a bit of what the member for Victoria Park said about the difficulties of prosecution. The powers are extremely strong.

In the case of physiotherapy, if someone goes out and says he is a physiotherapist and a complaint is made to the board, the board will investigate. If the person is found not to be a physiotherapist, that individual can be fined $30 000 for using a term that he is not entitled to use. We can go through the list of those professions. We want to have psychology, for example, in the legislation as a specialist position. All the medical specialists are in this list that has been endorsed by the Australian Medical Council, and there is a listing for "specialist in addiction medicine" and "specialist anaesthetist", "specialist dermatologist", and so on and so forth. The list of medical specialists covers three pages.

Dr J.M. Woollard: But, minister, it does not have "physician", and the Hippocratic oath that you swore as a medical practitioner states "I swear" as a qualified physician.

Dr K.D. HAMES: I will go through the issues the member has raised during consideration in detail.

Specialist professions are protected. I particularly wanted to talk about physiotherapists and psychologists. The argument about psychologists is very confusing. In this legislation the psychologist must have a specialty psychologist degree. The national board, which is, again, made up of psychologists from every state, made the recommendation to the ministerial council that there not be a so-called specialty using the words "specialist clinical psychologist"; they wanted the word "endorsed" used.

Mr R.H. Cook: That is because they work to a lower standard in other states.

Dr K.D. HAMES: Let me explain. There is no lower standard. The requirement for endorsement is not a lower standard—it is exactly the same standard as we have in Western Australia. Endorsed psychologists have to be registered psychologists first, so they have to do their normal course and become a psychologist, just as they do in other states and territories. But if they want to call themselves what are currently called specialist clinical psychologists, they have to do either an accredited doctorate in one of the approved areas of practice and a minimum of one year's supervised full-time practice with a board-approved supervisor, or an accredited masters in one of the approved areas, with a minimum of two years' approved practice, or any other that is equivalent to those two. That is what specialist clinical psychologists have to do. They explained to me that psychologists do their psychology degree, they do a masters degree, and then they have to do two years of supervision. That is what gives them that specialist qualification. Under this legislation, they cannot call themselves clinical psychologists unless they do exactly the same training. To say that the standards will be reduced is not true because a clinical psychologist in any state in Australia must obtain exactly the same qualifications needed to be a specialist in Western Australia.

Having said that, I do not understand why the reverse argument is not acceptable to the national board—that is, if we have legislation that calls them a specialist in Western Australia and they have to do that training anyway to be a clinical psychologist, why not just call them a specialist clinical psychologist, as they want to be called. I cannot see the negative in that.

Mr R.H. Cook: In fact, that would be upholding the interests of their profession.

Dr K.D. HAMES: Yes, I think so. That is why I raised that issue at the ministerial council and the ministers are aware. In fact, I have told all the psychologists from whom we have all been getting multiple emails that they do not have to convince me or themselves; they have to convince the ministers in the other states and territories. I have told them to go and work on the psychologists in other states. I have told them that this is a better outcome and to try to convince them to make it easier. Alternatively, they could go the national boards to try to convince the national board representatives, who are all psychologists, to change their minds. We just accepted the recommendation of the national Psychology Board; we did not overrule it or make any decisions.

The member for Maylands asked about the areas of endorsed practice. My understanding is that nine were put to them and seven were endorsed. I do not understand why two were left off, but I will send a copy of that component of the member for Maylands' contribution, and that of the members for Kwinana and Victoria Park, to the registration board stating that these are the comments and concerns of people in this state and asking it to have another look at the areas of endorsement and the use of the term "specialist". We will give the board copies of our legislation so that it can see what ours does—I hope everybody in the Speaker's gallery is listening to all these things I want them to do! They will be able to look at our legislation and see exactly why they are called specialists in this state, and we will see if we can get them to change.

The issue of physiotherapists, though, is somewhat different. The physiotherapists had a list of areas in which they wanted to be called specialists—I forget how many there were; maybe five or seven. Those areas were sports physiotherapy and the like. The board came back and said that it would not call them specialties; it would only endorse those areas of clinical practice.

Mr R.H. Cook: The national physio board?

Dr K.D. HAMES: The Physiotherapy Board of Australia made that recommendation to the ministerial council. While I have that recommendation going back to the board to get agreement, there is strong opposition to it from the other state health ministers, particularly the Queensland minister. Their argument is that some physiotherapists are trying to lock out generalists and saying that they have to do this one or that one if they want to call themselves specialists. If they want to be in both of them, they cannot. If someone is good at sports physio but wants to work in some other area of physio, that person would not be allowed to do that. A couple of the ministers hold the strong view that we should not have those specialty areas for exactly that reason. They have lots of physiotherapists, particularly in the hospitals, who want to do a broad range of things and not be locked into one area or another.

The member for Gosnells spoke about a senior physiotherapist. I am not sure what he said but I think he said that her job at the hospital was a senior physiotherapist in neurology. He said she got a specialist title from over east somewhere. I do not know if another state has a specialist title; we certainly do not here. That was one of the fields of clinical endorsement. A physiotherapist can still be clinically endorsed in an area of neurology. I do not see that there would be any downside to her being clinically endorsed. I have the same view in that if they want to specialise, I have no problems with them being called a specialist. That is why I brought it up again with the ministers. I am happy to say that the difficulty is not convincing me but convincing the other ministers. My job there is far harder than with the psychologists. I think I am getting a degree of support on the psychology argument. I am getting no support from other ministers on the physiotherapy argument. The reality is that if I am going to get that through, the member for Kwinana needs to work on state ministers elsewhere to convince them. I think he would be battling because they have very strong views. I have said that to the state physiotherapists. They understand and they know that this is not part of the national bill. They know that those areas of practice are decided by the national boards and recommended to the ministers. I have said that they have to convince other states and convince their own board that that is the way to go and that is the best way to do it.

Mr R.H. Cook: I thought the physiotherapists were going to be sorted out with the dental people later in the year.

Dr K.D. HAMES: Were going to what?

Mr R.H. Cook: I thought the final allocation or deliberation of the council was for dentists and physiotherapists.

Dr K.D. HAMES: I have not heard of any problem with the dentists.

Mr R.H. Cook: I never said there was any problem. I spoke to them and they confirmed that. In the communiqué that came out of the last council meeting, I thought you deferred physios and dentists.

Dr K.D. HAMES: We did. The physios were certainly deferred on the basis of my recommendation. The member is right; we deferred dentists as well. That is all to do with this argument of independence of dental therapists. When the former health minister was putting this recommendation to the Dental Board of Western Australia, that was one that did not get through. The opposition supported dental therapists having independence of practice from the dentists. The Dental Board strongly opposed that and started campaigning against us during the election. We still held that view. It is not up to us as a Liberal Party to champion that cause. The Dental Board will make the decision. It was about the final wording, and different states having different views about the wording and whether dental therapists must be independent or not.

Mr R.H. Cook: Can you advise us where you think that one's going?

Dr K.D. HAMES: I think the outcome is likely to be that dental therapists will not be able to be independent, which is the status quo, although a couple of state ministers, me included and one other, do support that view. The chances of it getting up are not great, although it is not impossible. Does the member agree with independence?

Mr R.H. Cook: I do.

Dr K.D. HAMES: The former minister did not agree.

Mr R.H. Cook: Yes. We parted company on that one. Obviously, there are limitations with dental therapists.

Dr K.D. HAMES: They need more training to be independent, without question. I do not see why they could not set up shop. I do not think it would take work away from the dentists. They have enough to do. The dental therapists would refer people to the dentists. They would find more stuff and they would treat more stuff but they would send the more complicated things on. It is a bit like the argument for nurse practitioners and doctors. Doctors are opposed to nurse practitioners but I think they would be of assistance. I do not support the AMA or the medical view on nurse practitioners.

Mr R.H. Cook: I find myself in the unfamiliar space of agreeing with you.

Dr K.D. HAMES: Within margins, of course. I will not get into that because in England we saw a totally independent nurse practitioner set-up where they were doing resuscitations on children on the way to hospital two or three times a week. GPs, doctors, would not be doing that. I thought that was beyond the boundaries.

The member for Kwinana raised a couple of issues that I have not covered, including psychologists not having their own board and sharing the board with South Australia. That is the case in five of the 10. The ones that have the state boards are nursing, midwifery, dental, physiotherapy and medical. The national boards of the others have decided that the numbers are not sufficient in those states to warrant the cost of full boards for each state so they have opted to share between some states to reduce their overall costs. I was a bit concerned when I heard that. I understood that there would be individual state boards for each profession. The national boards have the power to make that decision with the others so they decided to share. I had no objections from any of those boards saying they do not agree with it. If they had, I would have been fighting on their behalf. None of them have complained. I presume they think that sharing boards is in the best interests of their profession. If complaints are made, they are still dealt with on the level of the state in which they are in. They have smaller agencies in each state that they share as a board but they deal with complaints and issues on a state level depending where the complaint comes from. That is correct.

The other issue relates to costs. Again, this is an area of concern to me. When we went over to this first meeting and were told there would be national boards, we were told that the costs would come down, there would be efficiencies and everyone would work together. I said, "Yes, pull the other one." People who set up bureaucracies never end up doing it cheaper. In most professions, while it is more expensive, it is not a lot more expensive. Three of them—medical, dental and one other—have almost doubled their costs. Again, I raised this at the ministerial council, saying I was extremely unhappy. We were told that costs would reduce. Those costs were decided by the boards themselves so the Medical Board decided that that would be the registration cost, about double what exists in this state and certainly higher than all other states, although one only marginally. Part of the argument was that because people are registered in multiple states, the issue of getting them onto a single register would require extra administration costs and extra paperwork and it would cost more. We said at the ministerial council that it was not acceptable. We have now written back to those three boards asking them to justify the costs that we are putting forward. If it is to be a higher cost up-front because of the increased costs, they need to show where they get those figures from and how they make those calculations. From that, they have to guarantee to reduce them in the future once those initial overhead costs are gone. I am told anecdotally—I should not reveal the source; the member for Alfred Cove probably knows what it is—that in that meeting the comments were, "Well, what should the fees be? Let's do this: let's make sure we've got room to move, and let's make sure we don't get caught out. What do you reckon is a reasonable figure?" That is an atrocious way to work out what should be charged for registration. In fact, they were covering their tails and making sure they charged the maximum that could possibly be acceptable, and giving themselves plenty of money to start off with. That is totally unacceptable, so we will call them to account over the way they make payments.

I have very little time left so I will not go through all the issues raised by the AMA. There are about eight or 10 in all. I am sure the member for Alfred Cove, at least, if not the opposition, will raise issues on each of them as we go through the bill. I will deal with them specifically during consideration in detail.

Question put and passed.

Bill read a second time.

Leave denied to proceed forthwith to third reading.

Consideration in Detail

Clause 1: Short title —

Mr R.H. COOK: I beg your indulgence, Madam Acting Speaker, to allow me to use the opportunity during debate on the short title to clarify the generalities involved with the legislation. As I am sure you are aware, Madam Acting Speaker, the bill is very complex and, indeed, the member for Forrestfield raised his concerns earlier about the impact of mirror versus template legislation. I am not sure whether this is the most appropriate time, but because it goes to the generality of the legislation and the way it would work, I am hoping that we can discuss it in the context of the short title of the bill.

The ACTING SPEAKER (Mrs L.M. Harvey): Provided your discourse relates to the short title of the bill, I will allow it. This is not an opportunity for a second reading debate.

Mr R.H. COOK: The short title of the bill is the Health Practitioner Regulation National Law (WA) Bill. In the context of the bill's national characteristics, I wonder whether the minister can provide some clarification. I gather that when the Queensland legislation is changed, it automatically changes other states' legislation by virtue of the fact that theirs is template legislation. What will happen in Western Australia when we introduce mirror legislation and the two acts are inconsistent?

Dr K.D. HAMES: The member makes a good point. We have chosen not to have template legislation so that places an additional requirement on this state if there is agreement at ministerial council level to make amendments. When states have adopted template legislation, we at ministerial council agree there should be changes. In fact, we have done that because there have already been changes to that legislation. That then goes to the Queensland Parliament, is passed and automatically becomes law, without those other states having to do anything. In that case, Western Australia has to introduce amending legislation, which gives us the opportunity to debate the changes. If we do not agree to the changes, how that leaves us out of the national system and what power that national system has over us is a moot point. The national system is only as we agree to in this place. If, for example, it was decided to make the status of nurse practitioners next to God—it is probably there already—and we decided that we did not quite want them elevated to that level —

Mr R.H. Cook interjected.

Dr K.D. HAMES: I am using an extreme example because I cannot think of another one. The Deputy Leader of the Opposition will understand what I am trying to say. Our position in Western Australia might not then be consistent with the positions in other states. If that is the case, so be it, in my view. I do not think we want to be specifically bound. Decisions at ministerial council do not require a unanimous vote; they largely require a majority, although we either agree or we disagree. If we do not like something, we say that we are not doing it. I am sure the same applies in a range of other areas of national inconsistency. It was a good idea to give the example of the gas bill. In some cases our legislation will be different if that is what we decide. I guess at the end of the day the ministerial council will have to make a decision about how it responds to that situation. I cannot imagine the council deciding that whatever the change is, we should not be part of that national agreement. Those are the things we would have to take into consideration. I cannot see any area where that might get to that degree of such extreme difference of opinion between ministers on what happens within professions. Remember the legislation has to pass through both houses of Parliament in this state. One would think that we would be consistent. It may be the case, though—we seem to have control of the other place—that there might be something the opposition wanted to put through that we would defeat in the other place and it would not get through.

Mr R.H. Cook: I did not think of that scenario.

Dr K.D. HAMES: It might mean that there is something in which we are not consistent, and really there is nothing we can do about that. The alternative is to adopt template legislation. The downside of that is that the governments of states might change and it might be all Liberal ministers. Those ministers might decide to do something, and the Deputy Leader of the Opposition, who may then be the Western Australian minister, may not agree to that action, but he may get overridden. This state would then have to bring in whatever measure is involved. Therefore, it could work both ways.

Mr R.H. COOK: I just want to clarify it. Certainly the approach that we are taking, and that the minister is encouraging us to take, with this legislation is not to amend anything past division 51 really. I guess it is a question of the minister asking us to go through now and implement mirror legislation, because, on that basis, it will essentially make the whole thing null and void. But what the minister is saying is that he can envisage a situation in which our legislation is different from the national legislation. Therefore, does that not defeat the minister's argument?

Dr K.D. HAMES: That was a very tricky way to trap me into saying that, I must say! I think there are clear differences. This is a national law that we have agreed to in order to have national consistency across the professions. The member is right: we could have legislation that is different in Western Australia about a specific thing that affects only Western Australia. Remember that the national boards have that power. For example, if I put amendments in this legislation that provide that Western Australia will continue to manage its own disciplinary and complaints system, that has no binding effect on the national body. It has the power to make those decisions. If I want to get changes that make a difference to Western Australia, I have got to change the national law to have those effects. There is another example where, the member is right, there could be amendments. None of the amendments proposed by the Australian Medical Association could place Western Australia in a separate position, because the association in fact tried to buy into the national law on all those matters, and that cannot be done; it does not work like that. A good example is in the amendment that we are moving on contact lenses. All the states have agreed that contact lenses should be issued by prescription only.

Some of the states—Western Australia included—were going to go further and say that people have to have a prescription to get them. Now people are putting coloured lenses in show bags and they are causing medical problems, such as ulceration and infections in eyes. I have to say that I was met with strong resistance from within my own party against having such a clause, because that is not part of the national agreement. Only three states were going to do that, and so I am moving to take that part out. Even though I in fact agree with it, I am moving to take it out because it is not consistent across all the jurisdictions. Western Australia and, I think, South Australia and one other would be different from the other states and people could not provide coloured lenses at the chemist or whatever. In those cases, we could be different if we wanted to, but it has got to be something that specifically affects only things that happen here in Western Australia.

Mr R.H. COOK: I will not hold the house up too much longer with these matters. In another place at another time, if we were so inclined, we could build onto these laws aspects of, for instance, psychology practices in which we believe we stand proudly separate from the rest of the country on standards, specialities or whatever.

Dr K.D. HAMES: Yes, we could. I thought of doing that for the psychologists. What if we just moved that in Western Australia we had a specialist qualification? The problem with that is that it does not bind the national law, which recognises people from other states who do not have those qualifications. People coming from another state without necessarily those same conditions might come to Western Australia when they are registered nationally. They can call themselves whatever they are allowed to call themselves nationally but not in Western Australia That would make it difficult in terms of what they can do and cannot do. I am not saying that it is not an option. When I first thought of it, I thought that there was no way we could do that. Having looked now at what it says about people having to have those qualifications anyway, people coming from another state who had all those qualifications, if the qualifications required were the same, maybe could call themselves a specialist when they come here when they were not allowed to in other states. It is something that is worth thinking about.

Dr J.M. WOOLLARD: I just refer the minister again to the intergovernmental agreement, because the intergovernmental agreement says that we will implement as soon as practical legislation that is substantially similar. Because the words "substantially similar" are in that intergovernmental agreement signed off by Western Australia, I believe the amendments that I will put forward to the house tonight are substantially similar—in fact, I think they improve practice but they are similar—and will ensure that there is a better standard of practice in Western Australia. If the minister accepts these amendments that I will put forward, I would hope that when the ministers in the other states see these modifications and realise the benefits of these modifications, they would also seek to enact similar modifications to their legislation.

Mr R.H. COOK: In terms of the national legislation, I want to return momentarily to the example of dental therapists. What would be the interaction between the national board of dentists and the ministerial council on an inconsistency about how they wanted to apply practices across the profession? Say, for instance, the minister and the very wise Labor ministers for health wanted to introduce what the minister has talked about for dental therapists, and it was resisted by the national board on the basis that it wanted to defend or retain the status quo, how would that relationship work from the point of view of a national council and a national board having inconsistent views?

Dr K.D. HAMES: We are not as a ministerial council able to direct boards on what they do and do not register. We can stop them from doing some things but we cannot force them to do things that they do not want to do, so it would be up to the dental board to make decisions about the operation of dental therapists.

Mr R.H. COOK: In that context, how does one actually implement reform in any area of health if we are not in a position to evolve or develop the circumstances in which the professions operate if we lose that capacity to direct?

Dr K.D. HAMES: The capacity to reform, in effect, needs to come from within the professions. We get to a point that it is whoever is on the board. As state ministers, there is no capacity for us. We, in effect, lose the capacity to force change on professions that do not want it.

Dr J.M. WOOLLARD: I quote from Queensland's Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 —

> **Notification and publication of directions**
>
> (1) A copy of any direction given by the Ministerial Council to the National Agency is to be given to the Chairperson of the Agency Management Committee.

(2) A copy of any direction given by the Ministerial Council to a National Board is to be given to the Chairperson of the National Board.

My understanding of that is that the ministerial council can tell the national board what to do. That is not what the minister has just put on the record. That is section 12, "Notification and publication of directions", from Queensland's Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008.

The ACTING SPEAKER (Mrs L.M. Harvey): Member for Alfred Cove, we are on clause 1, which is the short title of the bill.

Dr J.M. WOOLLARD: This is in relation to clause 1, because this is talking about the scope of the bill and why this bill has been titled as it has. The minister has just made a statement to this house. Unless he is able to explain that statement, the minister may have unwittingly misled the house.

Dr K.D. HAMES: I have not misled the house. I have been able to find the clause that backs what I say, thankfully. There is a requirement to table, as the member says, when the ministerial council gives a direction, but there are limitations, as I said, on when and in what circumstances the ministerial council can give a direction. It comes a long way into the bill. I do not know if the house wants me to debate it now. I think we should deal with that when we get there.

Clause put and passed.

Clause 2: Commencement —

Dr K.D. HAMES: I move —

Page 2, line 6 — To delete "The local application provisions of this Act come" and substitute —

This Act comes

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 3 to 6 put and passed.

Clause 7: Exclusion of legislation of this jurisdiction —

Mr C.J. TALLENTIRE: I have a concern about clause 7, "The exclusion of legislation of this jurisdiction". It outlines matters relating to the Ombudsman; a body where people might reasonably expect that they could lodge a complaint. It outlines that that right to appeal to the Ombudsman would not exist any longer at a state level but it would be dealt with through national law. My concern is that that could be a very cumbersome process for someone in Western Australia, who would have to lodge a complaint through a national body. For it to be effective, we would need to have local representation. I am curious to hear from the minister how that might work.

Dr K.D. HAMES: In relation to the commonwealth, there is a commonwealth Ombudsman. They will appoint a national registration accreditation system—from now on we will call it N-RAS. If someone needs an issue dealt with by an Ombudsman, they will access the national Ombudsman, who has a state representative to deal with those issues.

Mr C.J. TALLENTIRE: I seek further clarification that there would be somebody here in Western Australia, or in the north of the state, if the origin of the complaint was in the Pilbara or the Kimberley, who would be readily accessible to a complainant.

Dr K.D. HAMES: I am advised that it will not necessarily be someone in Western Australia. That is the information I have been given. Sorry, just to clarify that: my earlier statement was incorrect. It is a nationally appointed Ombudsman. It is up to them then how they deal with issues in each state. They can send people over. They have the power to deal with those things.

Dr J.M. WOOLLARD: I wonder if the minister will clarify this for the house: I believe that the powers under the federal Freedom of Information Act are very different from the state's freedom of information powers. Could the minister clarify those powers and the differences that will make in terms of FOI requests?

Dr K.D. HAMES: We do not know the differences between the national Freedom of Information Act and the state Freedom of Information Act.

Dr J.M. WOOLLARD: I have been reading the two acts. The powers under those two acts are very different. I do not think we should be proceeding with this legislation if the minister is not able to explain to this house what

we are going to lose in relation to health care by going from a state-controlled Freedom of Information Act to a commonwealth-controlled Freedom of Information Act. I believe the debate should be adjourned.

Dr K.D. HAMES: My advice is that they both have the same fundamental aims and outcomes, but the actual individual details of comparison between the bills is not known, nor could we expect to know what those individual details are. We are adopting a national law on health, not debating the differences between freedom of information acts in different jurisdictions.

Mr R.H. COOK: I think, however, that it is obviously appropriate that if we have a situation where people take a local complaint to a state board for resolution—and that is indeed why the ministerial council has asked all the national boards to delegate that complaint authority to the state boards—surely it would be captured under state legislation in terms of the freedom of information process. We could remedy this simply by deleting paragraph (c) of clause 7 to make sure the Freedom of Information Act in Western Australia remains in force.

Dr J.M. WOOLLARD: I do not want to delay proceedings, but I ask that this clause lie on the table of the house so that the minister and other members of the house have an opportunity to look at the powers under both the federal and state Freedom of Information Acts to see whether this will make a difference to future applications.

Further consideration of the clause postponed, on motion by Dr K.D. Hames (Minister for Health).

Clause 8 put and passed.

Clause 9: Minister's direction —

Mr R.H. COOK: I assume that this deals with the transfer of assets and incomes from the current state registration boards to the new national boards. As the minister would be well aware, the Western Australian branch of the Australian Medical Association is quite aggrieved about the transfer of assets under the minister's direction to the national board. Is that the intent of the clause?

Dr K.D. HAMES: This clause requires the transfer of local registration authority funds to the national boards. The member for Kwinana is right; some concern was expressed by the Australian Medical Association about transferring assets to the national board. However, the Medical Board of WA does not share that concern. I have had long discussions with Professor Con Michael who is, I am sure, well respected by all members in this house. There are different situations. Some states have more assets than others. In the end they are all held by the medical profession, if not by the medical profession in this state. The Medical Board of WA has accumulated funds through my registration, as a member of our medical profession, over the years, although it is not a huge amount of money. The reality is that we are adopting a national scheme. It was never going to be easy. There will be some minor winners and losers. If the body that will be affected the most by this was seriously concerned—I refer to the Medical Board of WA—it would have been extremely unhappy about it, but it is not. It accepts that it has to provide registration funds a year in advance and outstanding liabilities from accumulated registration funds, which go to part of the national pool rather than the state pool. There was no other way of doing it. The board has agreed to it.

Dr J.M. WOOLLARD: I ask the minister to explain to the house how the amount of funds will be determined. Will the states be required to provide an equal amount? Will the money be based on the membership numbers for each of the states? The figure that has been bandied around as the amount that will be lost from Western Australia is $2 million. What will the amount be from each of the other states?

Dr K.D. HAMES: I understand that they need to pay one year of operating costs, plus any fees that are collected after the time of transfer.

Dr J.M. WOOLLARD: In the past the Nurses Board of WA has been very active in developing standards and competencies. I am disappointed to hear that this commonwealth grab for power is accompanied by a commonwealth grab for WA money.

Dr K.D. HAMES: That is obviously not correct. This has nothing to do with the commonwealth. As much as I enjoy bagging the commonwealth at any given opportunity, this is not a commonwealth grab for money. It is not commonwealth funded. The nursing money will go to the national nurses board. The Medical Board money will go to the national medical board. The money will still be owned by the nurses, albeit it will be owned by all nurses in Australia. The Nurses Board of WA has done an excellent job in fundraising over the years. We had discussions with the national body to try to work out a way to keep some of the nurses' money here and to use it for scholarships, which the Nurses Board pays for at present. Some jurisdictions have far greater amounts of money than we have in Western Australia and that money is going to the pool. We have agreed to look at funding those scholarships through the Department of Health to assist nurses with scholarships.

Dr J.M. WOOLLARD: Given that we have mutual recognition in WA and that we already have excellent boards in WA, it remains that local money from local boards will be used to create an empire in the eastern states.

Clause put and passed.

Clause 10: Police Commissioner may give criminal history information —

Mr R.H. COOK: Clause 10 refers to the powers of the Commissioner of Police to give criminal history information to national boards under the new legislation. Section 79 of the new act will require a national board to check a person's criminal history before giving that person medical professional registration. It is interesting that proposed section 135 refers to the board having that power but it does not refer to it having to use it. Clause 10 provides that the Commissioner of Police has the authority to provide a national board or other such agency with the criminal history of an applicant for registration or someone for whom they are doing a random check when that person is already registered. It is simply says that the Commissioner of Police may give criminal history information. It has been suggested that someone who has a spent conviction or who has served his time for a misdemeanour may have his health professional career held in check by an examination of his criminal history, even though the offence may have been committed a long time ago. It was also put to me—this is a point about which I will need clarification—that it is simply a question of whether someone has been charged. That struck me as being an extraordinary if that is the case. I very much doubt it. I ask the minister to clarify that.

Will the minister clarify for the house under clause 10(2) the circumstances in which a police commissioner would provide that information to the national board or to those other agencies, given that it is clearly an option that he or she may or may not execute?

Dr K.D. HAMES: I am advised that the reason for this clause is that without it, under our state law, the Commissioner of Police is not allowed to give information. This provision just clears the way for him to provide that information. In later parts of the bill, we will deal with what the national board has to do in terms of seeking criminal history background. I guess the Commissioner of Police may decide not to give criminal history information, but why would he? I do not think it is appropriate in this bill for us to be forcing the Commissioner of Police to do something, but this just allows him to do it; it is then up to the national board to seek that information. I can give no reason why a police minister, when someone is seeking registration of a doctor, might fail to reveal a particular criminal history.

Dr J.M. WOOLLARD: This in fact relates to proposed sections 77 and 79 of the national law, which I briefly discussed with the Attorney General; I believe he will come into the chamber when we discuss these clauses of the bill. I believe the government has signed another intergovernmental agreement in which Western Australia will provide to the other states information in relation to spent convictions. I am not sure whether the minister would like to discuss the issue of spent convictions now or later. For mature-aged nursing and medical graduates, who might be 50 or 60 years of age, this will mean that a minor offence in which they were involved 30 or 40 years ago will now go down on their record and become part of that national register. I have discussed with the Attorney General the fairness of including a serious offence or a recent offence in, say, the past 10 to 15 years. But it does seem to be pushing the boundaries to include a spent conviction from 30 or 40 years ago. People who have made an early mistake, which could be a minor mistake, will now have it included in their registration.

Quorum

Mr D.A. TEMPLEMAN: Mr Speaker, I draw your attention to the state of the house.

The SPEAKER: Ring the bells. A quorum is not present.

Dr K.D. Hames: Why? Why are you doing this?

Mr R.H. Cook: Because the Whip has a cunning plan!

Dr K.D. Hames: The Whip has a cunning plan!

Mr R.H. Cook: I don't know.

Dr K.D. Hames: What are you up to, member for Mandurah? It is not like we need extra people here. Are you planning a division? Just in relation to that, do you want to deal with it now or later? I will not be responding because I would prefer to deal with it when we get to the actual clause.

The SPEAKER: A quorum is present.

Debate Resumed

Mr R.H. COOK: I might be chasing a technical rabbit down a hypothetical burrow, but proposed section 79 of the national law states that the board must check the criminal record of a person seeking registration; whereas

clause 10 states that the police commissioner has discretion on whether that information will be provided. It is also not clear, as the member for Alfred Cove said, what the nature of that criminal history would be—whether it would be spent convictions, charges or things of that nature. I am not trying to hold up the discussion more than necessary. I am just curious about that aspect.

Dr J.M. WOOLLARD: I wonder whether I could draw to the minister's attention the fact that the Attorney General has come into the chamber, and ask the minister to give him a minute or two, as he is looking at clause 10 and proposed sections 77 and 79.

The SPEAKER: The question is that clause 10 stand as printed. All those in favour say aye —

Dr J.M. WOOLLARD: Mr Speaker, this section —

Dr K.D. Hames: Didn't she just speak? She has just spoken, I think.

The SPEAKER: Member for Alfred Cove, there has not been an intervening speaker and I need to put the question to the house that clause 10 stand as printed.

Mr R.H. COOK: I just asked the minister what he might have thought was a fairly trivial question, but it is one about which we should be quite clear, given the work that one of the health professionals has done in raising this issue; that is, the nature of the information that the police commissioner would provide under this clause, and indeed whether we may find that someone cannot be registered because the police commissioner may or may not provide that information.

Dr K.D. HAMES: As I said before, this clause is to allow the police commissioner to provide that information. There is a subsequent clause that deals with what the registration board does with that information. There are components that are required in terms of criminal history, and these are contained in the schedule. Members are getting to the schedule already. It refers to the meaning as —

> ***criminal history***, of a person, means the following —
>
> (a) every conviction of the person for an offence, in a participating jurisdiction of elsewhere, and whether before or after the commencement of this Law;
>
> (b) every plea of guilty or finding of guilt by a court …
>
> (c) every charge made against the person for an offence, in a participating jurisdiction … before or after the commencement of this Law;
>
> ***criminal history law*** means a law of a participating jurisdiction that provides that spent or other convictions …

The schedule goes on to refer to those criminal activities. However, whatever the member or I have on our criminal history is either recorded or it is not. Whether it is recorded as a finding of the court, depending on its nature—I really need the Attorney General here to help me with this—is whatever is recorded as a conviction. This gives the authority for the Commissioner of Police to provide that information to the national board. We will come later to what the national board has to do with that information and the decisions it can make based on that criminal history. It provides options for appeal so that someone who fails to be registered based on a criminal record can appeal that decision. There is a range of issues that we will deal with later. It is similar to what the national board does in relation to a spent conviction.

Mr R.H. Cook: What schedule was that?

Dr K.D. HAMES: It is in part 1, proposed section 5, of the schedule.

Clause put and passed.

Clause 11 put and passed.

Clause 12: Restriction on retail sale of contact lenses —

Dr K.D. HAMES: I signal my intention to oppose this clause. This clause on contact lenses was the one I spoke about earlier. It was opposed in our party room as something that should not be part of the national law. It prevents people from providing contact lenses to people in the same way that they were provided through a store. This is a clause that only a few states were putting in their legislation and I have agreed with our members that we will delete it.

Clause put and negatived.

Clauses 13 and 14 put and passed.

Clause 15: Acts repealed —

Mr R.H. COOK: Clause 15 repeals the state acts of Parliament that will no longer be necessary under the national scheme. Clause 15(m), which deals with the Psychologists Act, is of particular interest to me. It has been put to us by a number of psychology specialists that we should be simply leaving the Psychologists Act in place. That, as the minister observed, would create a dual system, but it may in fact strengthen the minister's hand in being able to negotiate on a more fulsome basis, for want of a better description, with his colleagues in other states. We could revisit a very small bill later in the year, once he had achieved the agreement of his colleagues to remove the Psychologists Act. But perhaps in the context of these discussions, he needs a bigger stick to bring about the reforms that I think everyone in this place has been nodding their heads in furious agreement over—that is, we want to preserve the specialist nature of the psychology profession. As I have said before, I acknowledge the minister's support for the retention of the specialist category for the psychology profession, and I ask him what would be the material effect of deleting clause 15(m), and also, to foreshadow, the effect of clause 16(2)(n).

Dr K.D. HAMES: I have two issues about that. Firstly, it is not possible, obviously, to separate those who are concerned about what is in the law and those who are not—that is, the rest of the psychologists who are in agreement with a national registration system. They have not approached the member for Kwinana because they do not have an issue. The member might find that just as many people would be beating on the member's door and saying, "Why are you doing this?" as the ones beating on the door saying, "No."

Mr R.H. Cook: Indeed.

Dr K.D. HAMES: As far as they are concerned, they are of the view that the legislation is going through and they will be part of a national registration system, which, to my understanding, is what they want.

Secondly, I am advised by my legal advisers that it would create a significant anomaly in how the state operates. This bill is being put through as state law, so there would be one state law that states one thing and another state law that states something totally different with different requirements. There would be two state laws affecting the same psychologists. All that is being done is not deleting the word "psychologist"; all the other things that relate to national registration, including the National Psychology Board, are still in place and still doing all those things they do, yet I still have a requirement, as state minister, to continue to operate the State Psychology Board. I think having a twin system such as that is not good practice or good management. We need to work on the issue that the psychologists have, which comes from the national board, not specifically from the legislation. We need to work in that forum and with the other ministers to achieve change.

Mr R.H. COOK: I accept the minister's arguments that this is not perhaps the best situation that we find ourselves in, but we find ourselves in a very bad situation indeed. It is a situation whereby we risk losing the standards we have in Western Australia in the recognition of a specialist if the minister is not successful in his negotiation with the other ministers later in the year. If the minister is not successful, what then?

Dr K.D. HAMES: I need to go back to the copy of the requirements of the Psychology Board of Australia. It is my contention that in the worst case scenario—that is, if we do not get that profession called a "specialist clinical psychologist"—in an actual practical sense there will be no difference in the requirement for educational qualifications. The national board requires that someone who wants to be a clinical psychologist has to do all of those things that they currently do. The same standard of training and education is required under the endorsement side of it as would be required without calling them a specialist. To be eligible for endorsement in one of the approved practices, an accredited doctorate in one of the approved areas of practice and a minimum one year of approved supervision, or, alternatively, an accredited masters degree, is required. I understand from the psychologists who I have talked to that that is what most of them have. On top of their normal psychology degree, they had done a three-year or four-year masters degree, and then a further two years of supervision approved by the board. They told me that they had done 10 years of training, which is amazing really when we think that in medicine we do six years, plus then we can do three more if we want to. That is an amazing degree of training, and I think they deserve to be recognised as specialists, having done that amount.

Mr R.H. Cook: Then why haven't we got to that point?

Dr K.D. HAMES: I do not know why. A lot of the psychologists on the board are from other states and they do not understand how our system works and do not see the need for using the word "specialist". The view they gave to one of my staff who was in contact with them is that the requirements are exactly the same, and what is everyone complaining about. The requirements for training for the education —

Mr R.H. Cook: If there is no complaint about it, they should just comply with the higher standard.

Dr K.D. HAMES: The member and I both agree on that. But I return to the statement the member made about the standard being lower—that is not correct. The standard will remain the same; it is the terminology that is different. I agree that the terminology should be "specialist", but it does not change the standard of education required.

Mr R.H. COOK: Can the minister clarify whether, nationally, we will have "clinical psychologists", or "psychologists (clinical endorsed)"?

Dr K.D. HAMES: No; in every other state and territory, if people want to call themselves clinical psychologists, they have to meet the standard of training. They cannot call themselves a clinical psychologist in another state unless they have done all this training; they would be just psychologists. This legislation creates a national standard that states that if a person wants to be a clinical psychologist or any of those other listed specialities such as clinical, counselling, forensic, clinical neuropsychology or organisational psychology, these are the only ways that can be achieved. A transition clause has been incorporated that enables a clinical psychologist to continue to use the title for three years—sorry, I misunderstood the advice I was given. The transition clause allows them to call themselves specialist psychologists for three years, but that does not seem to help because, to me, it is silly if they can call themselves a specialist for three years and then they have to stop. I will continue to pursue that. The only reason I stood was to reiterate that, from what I can see, in my view the standard of training required will not be any less. Other states will have to meet that standard and to be a clinical psychologist or work in any of those other areas a person will have to do that degree of training.

Mr R.H. COOK: Are there psychologists practising in other states who call themselves clinical psychologists, who do not have the same level of qualifications as those practising in Western Australia but who call themselves clinical psychologists?

Dr K.D. HAMES: My advice is that there may be some area of endorsement, but I do not know whether the term "clinical psychologist" is used in other states. In order to call themselves clinical psychologists, they would still need to meet those requirements. I presume they would have a transitional option—the same as our people do.

Clause put and passed.

Clauses 16 to 39 put and passed.

Debate adjourned, pursuant to standing orders.