

‘Options for Regulation of Unregistered Health Practitioners’

Submission to the Australian Health Ministers’ Advisory Council

24 May 2011

The Hearing Care Industry Association (HCIA) welcomes the opportunity to provide input into the National Consultation on unregistered health practitioners.

About the Hearing Care Industry Association

The Hearing Care Industry Association (HCIA) was incorporated as a Company Limited by Guarantee in March 2007. HCIA has at the core of its mission, its clients. It seeks to serve the Australian community by facilitating the delivery of world class hearing healthcare to all Australians.

Representing hearing healthcare retailers, HCIA provides a unified voice to all stakeholders, including government, the bureaucracy, the media, other professional bodies and the public.

HCIA members have clinics in over 440 locations throughout Australia. They employ over 500 professional staff between them and service many thousands of hearing impaired Australians every day.

They work with the Office of Hearing Services through its voucher programme and with private patients. We estimate that there are around 2,000 Audiologists in Australia and 500 Audiometrists. It is a highly feminised workforce and many practitioners work part-time. Our best estimate is that there are around 1,200 FTE audiologists working in Australia. HCIA members would employ a third of these.

Nature of the Problem

Clearly there is a problem with a small number of unregistered health practitioners. However, we would suggest that the risk varies between different disciplines.

Looking at the 11 public statements and prohibition orders by the NSW HCCC over the past two and a half years, multiple statements relate to Dental Technicians and Counselling / Psychotherapy. We also note, the NSW HCCC's prohibition order against the Australian Vaccination Network (AVN) in July 2010 has been widely applauded by Public Health bodies and others.

Risks Associated with Provision of Services

From the perspective of a body whose members are most likely to employ more unregistered Health Practitioners than any other group in Australia, we commend the work of the NSW HCCC and recognise the desirability of protecting the public. However, at the outset, we would like to point out a "risk" that appears not to have been considered is the "rush to regulate".

As a general principle, in Health Care it is desirable to have a service provided by the practitioner who is least qualified to do so, but nonetheless safe and competent to do so. In Australia, the reverse is often the case. We have Orthopaedic Surgeons operating on ingrown toenails; we have Ophthalmologists prescribing glasses and Specialist Psychiatrists providing routine mental health care. We would suggest that every piece of regulation; every piece of legislation; every registration board and many attempts to protect the public because something "might" happen, decreases the likelihood that work substitution may occur. This is a real risk in Hearing Services. Some Hearing Services are highly specialised and clearly can only be carried out by a highly qualified specialist practising cochlear manipulation.

On the other hand there are many aspects of the audiological caseload which can be performed by an Audiometrist and still present low risk to the client. Self-regulation of both professions (Audiologists and Audiometrists) and accreditation of the industry would manage public risk optimally. The process of self-regulation is well advanced.

We would suggest the risks to the public from Audiologists and Audiometrists is relatively low. Indeed, a former Commonwealth Chief Medical Officer is on the record as saying "the

reason Audiologists are not a registered profession is that no one has ever died from receiving audiological services.”

With regard to Audiologists and Audiometrists, looking at the data provided in the consultation document, we note that for NSW, there is no identified complaint against an Audiologist or Audiometrist in the five years 2005 -2010 (although it could be lumped in with ‘others’.)

In Victoria, we note that are only 4 complaints in the same 5 years. (2% of total complaints). Given that there are approximately 2,500 practitioners in Australia, we would suggest his is an extremely low level of complaint.

With regard to the WA data we would make two points:

1. Combining ‘Enquiry Only’ with ‘Written Complaints’ to give any sort of meaningful data, we would suggest is both meaningless and misleading. An enquiry is just that. To count it against a profession when there is no capacity for the other side of the case to be put, is perplexing and is open to the accusation of deliberately attempting to overstate the size of the problem.
2. WA does not categorise the profession, but the service, i.e. hearing services rather than audiology / audiometry. As these are high cost services, we suspect this relates to fees, charges and administrative processes, rather than professional services.

Objectives of Government Action

As people who have to run businesses, we would respectfully suggest Government objectives should be as follows:

- To have a response commensurate with the size of the risk.
- Not to duplicate existing consumer protection and other protection mechanisms.
- Not to automatically assume that all unregistered health professions are the same (as the consultation document suggests in some areas).
- To add as little cost as possible to business and practitioners.
- Not to have a definition of health service so wide as to be ridiculous (see below).
- To focus on serious complaints and not trivial issues.
- To allow self-regulation where it is appropriate.

On the last point, we do not generally disagree with Sylvan (2002) quoted on page 30 of the consultation document. We would point out in hearing care, public health and safety are generally not an issue and it is an industry with substantial competition, providing a solution for consumers with dissatisfaction about price, facilities or administrative staff.

What Happens Today With Hearing Care

All of the preceding, is not to say that as service providers we do not take extremely seriously the spectrum of issues from public safety through to public satisfaction. We just happen to believe that the public is being looked after pretty well with existing mechanisms.

That said, in early 2010, members of HCIA determined that HCIA should establish a Code of Conduct for Hearing Care Providers and a set of Standards against which hearing care practices could be accredited (this accreditation will be made available to all hearing care clinics regardless of membership of the HCIA).

The first part of this process is now complete. This followed a process of nation-wide consultation and followed input from all key stakeholders in hearing care in Australia, including the approved professional bodies and the peak consumer group. The Board has now approved a set of Standards (copy attached) and HCIA is currently in the process of engaging an Accreditation body to plan and undertake the actual Accreditation Assessments. We intend to introduce a Code of Conduct to our practitioners and clinics. This will be modelled on the NSW Code of Conduct.

There are three professional associations covering Audiologists and Audiometrists, who operate in a professional and competent manner. They work well.

What HCIA Would Like to See

HCIA accepts that some change needs to occur. We understand that the Audiological Society of Australia (ASA) has made a submission suggesting that a system of self-regulation by professional bodies be implemented. We would support this within the Hearing Industry, provided it would apply to all three professional bodies in Hearing Care. We believe this combined accreditation, considered with accreditation of the physical infrastructure, would provide good public protection for this low risk area.

We would therefore suggest those industries / professional areas that are low risk and have in place, or are willing to introduce, self-regulation, should be allowed to do so.

Any statutory scheme, should apply only to those areas that are higher risk or are unwilling or unable to self-regulate.

If there are practical reasons that this cannot be implemented, then we would like to see a system introduced along the lines of the NSW legislation with two serious provisos.

1. The definition of Health Service is important. While we do not wish to trivialise the matter we would point out:
 - Under the ACT definition, a health service is defined as a service provided “..... maintaining or improving emotional health, comfort or wellbeing of the individual”, there is presumably nothing stopping this covering highly personal services provided by someone with no healthcare association whatsoever, and;
 - Under the SA definition a specific example of a health service is given as, “a laundry, dry-cleaning, catering, or the support service provided in a hospital, health institution or aged care facility. “ Presumably here, there is nothing to stop a flood of complaints about uncomfortable sheets or bad food. We would suggest both definitions are pretty trivial and need to be changed so as not to bring into disrepute the whole system.

In our view, the Western Australian definition is much more appropriate.

2. Our members operate nationally so having nationally consistent regulations is extremely important. That said, we can see no justification whatsoever for setting up a new national infrastructure for this. Nationally consistent State legislation would seem perfectly adequate.

Indeed, we note on page 16 of the consultation document (in reference to the NSW scheme) “the cost of the regime has been low... and no additional infrastructure has been required.” A new national infrastructure will inevitably involve higher costs which will be passed onto business or practitioners. This makes no sense when State and Territory governments already have infrastructure in place to deal with them.

We urge AHMAC to note that HCIA has spent a considerable amount of time, money and effort on developing its own accreditation standards and code of conduct for its clinics around the country. We also urge AHMAC to note that the professional bodies are moving to accreditation of practitioners.

We would urge AHMAC to focus on those unregistered health professionals who present a risk to the public.

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