



Regulation of the Health Professions in Victoria: Options for Structural and Legislative Reform

**SUPPLEMENTARY SUBMISSION TO
DEPARTMENT OF HUMAN SERVICES
BY AUSTRALIAN DENTAL ASSOCIATION
VICTORIAN BRANCH INC.**

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ADAVB RESPONSE TO OPTIONS PAPER

Review of Regulation of the Health Professions in Victoria

May 2005

Welcome measures:

- The ADAVB welcomes the opportunity to summarise its response to the options for structural and legislative reform arising from the Review of Regulation of the Health Professions in Victoria. Discussions with our Council on 9 May were also appreciated, in particular reassurance that ‘radical reform’ is not required and that only fine tuning is being considered.
- We especially welcome retention of protection of practice as well as title for dental practice.
- External review of codes and guidelines to ensure compliance with principle of good regulation is also particularly welcome.
- Option 1a, involving updating of template provisions is preferred.
- Most of the recommendations are supported - either in full or with qualifications.

Matters of continuing concern (12 proposals opposed):

- Stronger consumer participation and a shift to a consumer court model seem intended. Many boards achieve good results because the members see themselves serving the community. Largely the system works and is relatively inexpensive. There are already other suitable avenues for consumer complaints to be dealt with effectively, without converting the registration boards into another consumer forum.
- The suggestion that all proposals for workforce change are in the public interest is rejected, as is inference that they are all contested (refer p.3 of the Options Paper).
- There is a suggestion however, that the legislation may be used for stronger workforce policy moves also, and this would be opposed by the ADAVB. Changes to the scope of duties of various personnel should only be considered on the basis of evidence that it is required, and this should not occur as a standard response to workforce shortages, nor in a manner which avoids the obligation to provide adequate training to be able to safely and proficiently provide the treatment concerned.
- Ministerial or Departmental interference with Board independence is possible under the proposals. The Minister is a purchaser of dental services and thus must take care to declare a conflict of interest. Separation of powers also needs to be maintained.
- Overall, administrative changes will increase costs to registrants especially with the possibility that all practices will be treated as Day Procedures Centres. There has been an ever rising tide of regulatory measures which is increasingly of concern to practitioners due to the time and compliance risk involved. There needs to be some mechanism by which the net effect of all regulation of dentistry can be gauged in the interests of avoiding a mass exodus due to early retirement - such as was seen with the medical indemnity crisis in the medical profession. Such regulations and codes include those promulgated by non-health regulators such as the ATO, water boards, EPA and local government.
- The status of Codes and guidelines remains of concern. We understand that guidelines are intended to be flexible to allow for scientific and other developments to influence their contents. If this is the case, they need to be contestable in a hearing rather than making a breach of a code an ipso facto breach of an Act or Regulations.
- The “Bringing in the Consumer Perspective” study completed by the HIC and Resolution Resource Network was flawed, as it tended to focus on the long term dissatisfied and was largely about medical complaint issues. It also failed to take account of the professional perspectives or to establish whether the current complaint and judicial systems collectively offered the level of responsiveness sought by aggrieved parties.

Reform Proposal (RP) No. / Topic	Comment
1. That the current Victorian model of regulation of the health professions, based on protection of title rather than protection of practice, be retained, subject to modifications outlined in this paper.	Opposed - Protection of practice is required in dentistry - see RP No. 29 – which is supported.
2. That the offences for use of restricted professional titles be amended to ensure that they specifically capture titles when used as practice descriptors rather than as professional titles.	Supported - But ensure that both forms of misuse are covered.
3. That the existing model of self-funding of registration boards be retained, with provision for shared board/government funding of joint projects as negotiated from time to time.	Qualified support
4. That the legislation include a role for all registration boards to report to the Minister any concerns about the health system in Victoria that arise from carrying out their functions.	Supported
5. That the legislation make provision for separate registers of nurses and midwives, and, if profession specific registration boards are retained, a single ‘Nurses and Midwives Registration Board’.	No comment
6. That there be provision within legislation for the establishment of statutory committees to provide access to specific expertise for nursing and midwifery where required.	No comment
7. That the legislation make provision for registration of medical radiation technologists and repeal the Health (Medical Radiation Technologists) Regulations and any relevant provisions of the Health Act.	No comment
Option 1A: Update the template provisions	Qualified Support - Seems to retain the status quo, although might increase the size of Boards or require an investigative committee comprised of non-Board members. Amendments to separate Acts can be addressed via omnibus Bills.
Option 1B: A single ‘Health Professionals Registration Act’	Opposed

Option 2A: A separate 'Health Professions Tribunal'	Opposed - "... of a serious nature" will need to be defined. A division within VCAT could possibly provide some parity across professions, where presently medicos get a reprimand and dentists get suspension for similar misdemeanors. Conversely, a specialist tribunal has the possibility of remaining isolated and offering less parity. Added cost and delays are key negatives here.
Option 2B: Reform of investigations function	Opposed - We do not agree with the introduction of an appeal path for complainants if the Disciplinary body has lay and legal members outnumbering members of the profession. The additional red line available to Complainants establishes a second trial for the same offence. There have been a few inconsistencies, but to open this channel up to every complainant (especially the vexatious few) is not justified where the VCAT avenue remains available to them. The HSC needs to remain focused on conciliation rather than prosecution.
Option 3A: Internal board review	Opposed - We do not see any value in giving complainants a right to an internal review, as postulated. Except that this would be preferable to the HSC review as proposed in Model 3B.
Option 3B: External review by Health Services Commissioner	Opposed - The HSC should receive complaints, investigate them, and then conciliate them as well. It should not have a Tribunal role in its charter. This should be addressed through VCAT.
Option 3C: External review by VCAT/Health Professions' Tribunal	Opposed - Informal complaints would have right of appeal and thus create significant problems.
Option 4: A single 'Office of the Health Professions'	Opposed - It also leaves open the question of how to investigate and then discipline.
Option 5: A single 'Health Professions Council'	Opposed – too risky.
8. That the legislation include provisions to enable the granting of temporary registration to interstate or overseas trained practitioners in response to specific service need.	Opposed - May create a loophole that could be used to hurt the public – e.g. flood the market with overseas trained practitioners who have not met minimum standards. A sunset clause is required. Would only be acceptable if safeguards as per the Public Sector Dental Workforce Scheme were introduced.
9. That the legislation include discretionary powers for all registration boards to register students along the lines of the provisions contained in the Pharmacy Practice Act 2004.	Supported - Already in the Dental Practice Act.
10. That the legislation be amended to include provisions that allow for interim registration.	Qualified Support - Consider professional indemnity issues and the need to follow the Australian Dental Council (ADC) model.

11. That the legislation include provisions that allow registration of practitioners as ‘non-practising’.	Supported - Not harmful, and a positive recognition of retired practitioners and academic and administrative professionals. Such practitioners should be exempt from mandatory CPD requirements (assuming these apply to other registered persons).
12. That the legislation include provisions that allow the entry of recognised specialist qualifications on the practitioner registers.	Supported
13. That the legislation include a provision that empowers the Minister for Health to prescribe qualifications for registration purposes, following consultation with relevant registration boards, educational institutions and qualification assessment and approval authorities,	Opposed - This is the role of the Board, and suggests political interference for workforce manipulation purposes. In conjunction with RP8 could see the Minister flood the market without reference to the ADC model.
14. That the outcomes of the Australian Health Ministers Advisory Council (AHMAC) project to develop nationally uniform medical registration arrangements be used as a template for pursuing discussions with other jurisdictions regarding a nationally uniform approach to registration of all health professions.	Supported – But beware lowest common denominator outcomes.
15. That the provisions of the Pharmacy Practice Act 2004 provide the template for drafting provisions on public access to register information, ensuring that the public has sufficient access to information regarding the status of practitioner registrations and any conditions, limitations or restrictions.	Qualified support - Information regarding the status of a practitioner, i.e. conditions or suspension, should only be available on the internet <u>while the condition or suspension is in force</u> .
16. That any recommendations for reform arising from the Nationally Consistent Medical Registration Legislation Project be taken into consideration during drafting.	No comment
17. That the legislation include strengthened powers for boards to require registrants to provide information at annual renewal and during the registration period.	Opposed - Unnecessary, and adds time and cost to registration. Registered persons are already reporting on several matters such as PI, claims, and CPD attendance.
18. That the legislation be amended to include a role for registration boards in collecting and supplying data requested by the Minister for workforce planning purposes, and statutory powers to require practitioners complete a de-identified and confidential workforce census as a requirement of registration/renewal of registration.	Supported - The lack of current workforce data, including information about non-registered but essential personnel such as dental assistants, is a key failing of present systems. Boards should therefore seek information on associated non-registered persons such as dental and pharmacy assistants.
19. That national work on the establishment of unique identifiers and the Index of Medical Practitioners inform such data collections in Victoria.	No comment

<p>20. That the legislation include provisions similar to those in the Pharmacy Practice Act 2004, to empower registration boards to issue guidelines about acceptable PII arrangements and require PII as a condition of registration and renewal of registration.</p>	<p>Supported - Status quo supported for both Dental and Pharmacy Practice Acts.</p>
<p>21. That the terminology ‘unsatisfactory conduct’ and ‘professional misconduct’ be adopted to replace the terms ‘unprofessional conduct not of a serious nature’ and ‘unprofessional conduct of a serious nature’.</p>	<p>Supported</p>
<p>22. That the legislation include standard powers for authorised officers to enter and search premises with a warrant.</p>	<p>Supported</p>
<p>23. That the current powers of the Pharmacy Board to enter and search pharmacy premises without a warrant during business hours be retained.</p>	<p>Supported - This needs to be addressed with sensitivity to the relationship between the practice and the community.</p>
<p>24. That the provisions in section 41(1)(c) of the Pharmacy Practice Act 2004 be applied to all health professions in relation to the investigation of notifications.</p>	<p>Qualified support - The Medical Practice Board provides for referral of impaired practitioners to the Victorian Doctors’ Health Program, where confidential support can be provided. No equivalent measures are available for other health care providers. In the light of present and projected workforce shortages, and in terms of providing equitable support for all registered providers, the Department should use this opportunity to establish a common central system by which all needy practitioners can be provided with assistance to ensure that they remain registered and available to provide the community with treatment.</p>
<p>25. That reforms to the provisions contained in the Pharmacy Practice Act 2004 be considered to empower boards to:</p> <p style="padding-left: 40px;">Appoint registered practitioners other than medical providers to conduct health examinations where appropriate.</p> <p style="padding-left: 40px;">Have discretion to not provide notice of a complaint to a practitioner, where this is considered to place a person or persons at risk of harassment, intimidation or harm.</p>	<p>Qualified support</p>
<p>26. That, subject to considering the effect of any structural reforms, the provisions in the Pharmacy Practice Act 2004 be used as the template in relation to pre-hearing conferences, making of determinations, suppression orders, and the issue of summons.</p>	<p>Qualified support</p>

<p>27. That the Minister request that all registration boards explore the feasibility of developing a single set of advertising guidelines that address advertising by all the registered health professions.</p>	<p>Supported</p>
<p>28. That any recommendations arising from the Inquiry by the Health Services Commissioner be taken into account during drafting.</p>	<p>Supported - The advertising of cancer health services by a person previously registered as a dentist is but one of the appalling outcomes of previous de-regulation. A cursory examination of the dental section in the Melbourne Yellow Pages for 2005, will reveal that hundreds of thousands of dollars, if not millions, are now being spent on promotion of cosmetic dental services. There is no evidence that these advertisements contain information that can assist the public to gain better insight into the selection of a registered dental care provider, and indeed a significant number of those spending the largest amounts on dental advertisements in this medium have a history of professional misconduct. The Dental Practice Board has felt obliged to spend over \$50,000 of registration fees collected from the profession on a full page advertisement of its own to alert the public to the risks of being taken in by these advertisements. In our view the public was better off before advertising was de-regulated in 1996.</p>

<p>29. Given the level of risk associated with dental practice, legislated restrictions on who can practise dentistry should be retained. However, further consideration should be given to legislative definition adopted, that is, whether it should be a broad scope of practice definition or limited to those core practices considered most risky and intrusive.</p>	<p>Supported - but don't change the definition.</p> <p>In the preamble to this RP it states that the “ Health Services (Private Hospitals and Day Procedures Centres) Regulations do not apply to dental surgeries.” This is incorrect in so far as these regulations do apply to several oral and maxillofacial surgery practices. RP 29 could usefully include reference to the role of the Australian Dental Council in accrediting undergraduate and postgraduate courses for dentists, dental specialists and allied dental personnel. The RP should recommend that the scope of practice as it is expressed in current legislation be retained. Many hours were spent fairly recently in negotiations between all affected parties to agree on the present definition, so this should be retained. Infection control has a large component of risk management. Should apply to all aspects of dentistry including examination.</p> <p>We understand that ‘risky and intrusive’ is intended cover any form of therapy that involves significant risks of adverse patient reactions, or danger to practitioners and staff. We suggest it may need to be further refined for each field. In dentistry it would be helpful to include reference to invasive or exposure prone procedures, defined as follows:</p> <p>An <i>invasive procedure</i> is any procedure that either pierces the skin or mucous membrane or enters a body cavity or organ. This includes surgical entry into tissues, cavities, organs or repair of traumatic injuries.</p> <p>Consideration should be given to employing appropriate risk minimisation techniques to avoid injury to the operator or assistant.</p> <p><i>Exposure prone procedures</i> are considered to be a subset of ‘invasive procedures’. It is a term usually characterised by the potential for direct contact between the skin (usually finger or thumb) of the health care worker and sharp surgical instruments, needles or sharp tissue (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth).</p>
<p>30. That a policy position on the question of whether the scope of optometry practice should be restricted in legislation be reserved to allow further consultation with stakeholders.</p>	<p>No comment</p>
<p>31. That the Health Services Act be amended to ensure that the practice of laser eye surgery and other risky and intrusive cosmetic surgery procedures such as complex liposuction are captured under the definition of a 'day procedures centre'.</p>	<p>Qualified support</p>

<p>32. That the Health Services (Private Hospitals and Day Procedures Centres) Regulations 2002 be amended to ensure they apply to any premises where such procedures are carried out, whether or not these procedures constitute a 'major activity' of those premises.</p>	<p>Opposed - This could have the potential to turn every dental practice in the State into a Day Procedures Centre – an impractical and unnecessary outcome. This has the potential to drive hundreds of dentists into early retirement – which would hardly be likely to promote the desired access to care.</p>
<p>33. That the health practitioner legislation include powers to require that advertising of certain specified risky and intrusive procedures carry warning labels approved by the Minister.</p>	<p>Supported</p>
<p>34. That the Medical Practitioners Board be empowered to issue Ministerially approved guidelines about the practice of cosmetic surgery, and that these guidelines require practitioners to:</p> <ul style="list-style-type: none"> Ensure that advertising is not false or misleading and does not encourage an unreasonable expectation of beneficial treatment. Provide prospective patients with a cooling off period before undertaking certain specified risky and intrusive procedures and encourage them to undergo counseling prior to consenting to the procedure; Providing balanced written information for discussion with patients on the risks associated with any cosmetic procedure; Provide an interpreter where necessary and/or the information be provided in the patient's preferred language; and that an anaesthetist be available on site for certain specified risky and intrusive procedures. 	<p>Supported - And they should be extended to cosmetic procedures in dentistry and other participating health professions.</p>
<p>35. That the legislation make provision to retain limited prescribing rights for optometrists (drugs for the treatment of anterior eye disease), nurse practitioners (various drug formularies depending on category of nurse practitioner) and Chinese medicine practitioners (Schedule 1 herbs).</p>	<p>No comment</p>
<p>36. That the legislation make provision for limited prescribing rights for podiatrists appropriate to their scope of practice.</p>	<p>No comment</p>

<p>37. That the legislation make provision for the following in relation to limited prescribing rights:</p> <p>A board responsible for overseeing limited prescribing rights for a profession be empowered to endorse suitably qualified practitioners to be authorised under the DPCS Act to prescribe drugs.</p> <p>The board be required to have in place a statutory committee with a membership and functions similar to those set out in sections 79(3) and 80(2) of the Nurses Act.</p> <p>The Minister have statutory power to receive applications from a board for approval of endorsed practitioners to prescribe a drug, type or class of drugs, including, where relevant, type of preparation and route of administration, and to approve this application for the purposes of authorisation of endorsed practitioners under the DPCS Act.</p> <p>The Minister have the power to determine matters to be addressed in an application for approval of prescribing rights, including:</p> <ul style="list-style-type: none"> o The scope of the approval sought. o The consultation undertaken by the board to determine the need for and scope of the limited prescribing rights, including what expertise it has accessed. o The arrangements the Board has made to ensure that existing and newly endorsed practitioners have adequate skills and knowledge to prescribe the drugs. o The safeguards in place to ensure safe prescribing, including any clinical practice guidelines, CPD requirements etc. <p>The Minister have statutory power to amend, vary or withdraw an approval at any time.</p> <p>The DPCS Act be amended to authorise endorsed practitioners to obtain possess, use sell or supply any Schedule 2,3, or 4 poison as long as it is consistent with the terms of the Ministerial approval and the endorsement granted by the registration board.</p> <p>That once the Minister has granted an approval, the registration board be empowered to issue clinical practice guidelines for endorsed practitioners, and to amend from time to time any associated drug formulary, as long as such changes are within the scope of the approval granted by the Minister and the requirements of the DPCS Act.</p> <p>.</p>	<p>Opposed - ADAVB would prefer that prescribing rights remain as in current legislation.</p>
<p>38. That the Pharmacy Practice Act 2004 provide the template for drafting provisions to empower boards to regulate professional performance for all the registered health professions.</p>	<p>Qualified support - Link to provision of confidential support for impaired practitioners.</p>

39. That the legislation clarify that registration boards are responsible for ensuring registrants comply with the requirements of the Health Act and Health (Infectious Diseases) Regulations.	Supported
40. That registration boards be encouraged to coordinate the development of practice based guidelines that address infection control requirements for registered practitioners.	Supported - There could be a problem if the Department were to set the bar too low. However all such codes and guidelines should be evidence-based .
41. That registration boards be encouraged to co-operate in the development of suitable practice guidelines on integration and use of complementary therapies in registrants' practice.	Supported - Consistency across all fields is obviously important here.
42. The legislation provide for board powers to settle a matter by mutual consent between a practitioner, a complainant at the investigations stage, without the need to proceed to a hearing.	Qualified Support - This is already the role of the HSC, but if other forms of conciliation are required then allow Boards to refer to other suitable bodies.
43. The legislation provide for board powers to impose conditions, limitations or restrictions on a practitioner's registration, by agreement, following an informal hearing..	Opposed - This could have the effect of increasing the status or impact of an informal hearing to a formal hearing with increased costs
44. That fines provided in section 69(2)(f) of the Pharmacy Practice Act be adopted as the template.	Qualified support
45. That the legislation include provision for when cancelling or suspending the registration of a practitioner, the ability to make a court enforceable order prohibiting that practitioner from providing services of the same or similar kind using an unregulated title.	Support
46. That the legislation include a requirement that registration boards maintain a publicly accessible register of persons whose registration has been suspended or cancelled.	Qualified support - Only while the suspension is in force.
47. That sections 69(2)(j) and 69(5) of the Pharmacy Practice Act 2004 be used as the template for drafting provisions that empower a registration board or tribunal to require a practitioner found to have engaged in serious unprofessional conduct to pay the reasonable costs and expenses of the board or tribunal in the conduct of a formal hearing (or equivalent).	Opposed - This seems to be double jeopardy and an extra penalty. It effectively changes the system from one of correction and protection to one of punishment. If extra costs were to be borne then reduction in the level of penalties for breach should be considered as an offset.

<p>48. That the legislation include powers for registration boards to specify a period during which a practitioner whose registration has been cancelled may not re-apply for registration.</p>	<p>Supported - If registration is cancelled for a period, does it not follow that while an application could be made during that period, no reinstatement can occur until the end of the period?</p>
<p>49. That the legislation include provisions making it an offence for a person to direct or incite a registered practitioner to engage in unprofessional conduct, with sections 93-100 of the Pharmacy Practice Act 2004 providing a suitable template.</p>	<p>Supported - Consistent with our earlier submission. Could be strengthened by adding “or knowingly allow” after incite.</p>
<p>50. That the legislation retain the current model in which registration authorities are independent statutory authorities required to provide information to the Minister and take notice of the Minister’s views, but are not subject to direction by the Minister.</p>	<p>Supported - The convention that ministers of state should not involve themselves in operational policing matters is a balancing mechanism within the executive branch of government designed to prevent abuses of power. An apolitical, professional public service that serves the government of the day without fear or favour is another balancing mechanism to a politicised executive.</p>
<p>51. That the Department continue to monitor the operation of the health practitioner regulation system and facilitate coordination and cooperation between registration boards.</p>	<p>Qualified support – This could be a double edged sword. On the one hand it could help to ensure equitable outcome on such matters as doctor’s and dentists health support systems. On the other, it could contradict RP 50, which says that “registration authorities are... not subject to direction by the Minister.” This is a correct approach to separation of powers. However, RP 51 proposes that “the Department ... provide policy direction, and scrutinize board policies, guidelines and reports.” This could contradict RP 50 and become improper. If this is really meant to happen then Model 1B and Model 5 could have difficulties due to the establishment of a single controlling authority.</p>
<p>52. That the legislation include a provision requiring registration boards to consult the Minister, the profession and consumer representatives before publishing any codes of practice or guidelines with the exception of any guidelines that require immediate issue in order to address matters of immediate public health and safety.</p>	<p>Supported - This suggests that there could be a way of having some review and parity before codes get pushed onto the profession. Audit of these instruments by the Victorian Competition and Efficiency Commission (VCEC), responsible for “good regulation” is also in order as recommended by the Inquiry into the Subordinate Legislation Act.</p>
<p>53. That the legislation include a requirement that any Board proposed code that addresses matters of requirements for registration, scope of practice, supervision requirements, advertising or where Government has overlapping statutory responsibilities, be approved by the Minister prior to release and, if the Minister requires, be published in the Government Gazette.</p>	<p>Supported - ADAVB has argued for adherence to principles of good regulation, and this reform is consistent with this. Active involvement of the VCEC is desirable.</p>
<p>54. That the Department negotiate, as required, with registration boards to attend board meetings.</p>	<p>Opposed - Conflicts with RP 50. Potentially a time bomb. Flies in the face of Ministerial separation from day to day activities of Boards.</p>

<p>55. That there be a statutory requirement for registration boards to make the minutes of board meetings publicly available (preserving privacy and confidentiality of material where necessary).</p>	<p>Qualified Support - Open hearings are already a feature of DPBV operation and should remain so. However, publishing minutes will increase work for the board and will therefore decrease the time available for other important work.</p>
<p>56. That the Minister request advice from all registration boards on the feasibility of structuring board meeting agendas to allow for at least parts of board meetings to be open to the public.</p>	<p>Supported - See comments on RP 55 above.</p>
<p>57. That the legislation allow for the Minister to appoint between 9 and 12 members to each board, with flexibility for the Minister to increase the number of members as necessary.</p>	<p>Supported - Larger board structures are required, beyond the template, where multiple occupations are being regulated. Most Board members should be expert to ensure that they are not able to be ‘bluffed’ by clinicians, or wrong-footed by lack of clinical insights.</p>
<p>58. That the legislation retain flexibility for the Minister to recommend for appointment the most suitable and experienced practitioner members to registration boards, without specifying in detail the sectors or work roles such practitioner members must occupy to be eligible for appointment, except where a board that regulates multiple professions.</p>	<p>Qualified support - Partial agreement, dentists, therapy, hygienists, and prosthetists, should be on DPBV in proportion to numbers registered</p>
<p>59. That the legislation provide more flexibility for the Minister to appoint up to half a boards’ members from persons who are not practitioners of that profession.</p>	<p>Opposed - These would be an issue, as board credibility with profession relies on colleagues leading the board.</p>
<p>60. That the legislation include provision for the Minister to have the flexibility to recommend for appointment to office bearing positions any of the members of the board.</p>	<p>Opposed - Appointment of Board members requires formalization and due process to ensure all parties are happy with the Board. The selection process currently being employed is working however the ADAVB should have a formal nominee involved. The potential for an office bearer to be required to be an expert witness, as was recently the case for the DPBV President, requires that these persons be drawn from the profession regulated.</p>
<p>61. That three-year terms be retained, with no legislative cap on the number of successive terms for board members.</p>	<p>Opposed - We have seen evidence in another jurisdiction of the problems that arise when people seem to be appointed for life. A maximum of three terms should be set.</p>
<p>62. That the legislation include provision for the Minister to directly appoint to casual board vacancies from the list of persons pre-approved by Governor in Council.</p>	<p>Supported</p>

63. That the legislation include a provision that allows a board member whose term has expired to continue to sit on the Board for a period of up to 3 months while the position is being filled or while completing their role on a hearing panel or other statutory committee of the Board.	Supported
64. That a Departmental review of sitting fees be conducted within whole of Government guidelines, with a view to addressing inequities in current payment rates and establishing consistent arrangements for payment across registration boards for the various functions.	Supported
65. That a suitable mechanism for indexation of sitting fees be established.	Supported
66. That the legislation include a specific power for registration boards to charge a fee for course approval, where this function is carried out by the board.	N/A - ADC does course approval for dentistry so not relevant.
67. That the Department work with the Boards to develop a program of induction training for all new board members.	Supported - It is vitally important that Board members understand the nature of their role and principles of good governance, including avoidance of conflict of interest.
68. That the boards establish a Consumer Advisory Panel, initially comprising lay members from all Boards, to provide advice on current and emerging issues impacting on practitioner regulation from a consumer perspective.	Qualified Support - Such a panel should not have any power to change the focus of Board operations from a primarily protective role to one of punishment for registered persons.
69. That the legislation make provision for the registration and reporting years to be aligned with the financial year.	Supported
70. That the Minister request registration boards to provide, on an annual basis, a single consolidated report of data on complaints/notifications and disciplinary processes.	Supported

END.

PURPOSES

The objectives of the ADAVB are to promote the:

- improvement of the dental health of the public;
- art and science of dentistry; and
- highest standards of professional dental care

MEMBERSHIP

- Approximately 2250 Dentists in private and public practice, and 4th & 5th year students
- 95% of registered private practitioners
- 10 suburban and 7 country groups

MEMBER SERVICES & FUNCTIONS

- Continuing Professional Development Program
- Dental health education programs (eg. Dental Awareness Month)
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent Graduate support
- Dental Assistant Training update seminars
- Member Service Plans (eg Professional Insurances; preferred suppliers)
- Industrial relations advice and representation
- Defence and legal support
- Advice on Practice Management
- Quality Assurance (including Doctors Health Advisory Service)
- Benevolent Fund
- Library and resource collection
- Political representation
- Representation to Government bodies
- Superannuation (Professional Provident Fund)
- Sports and social functions
- Publications – Newsletter, Journal, Award details, Manuals etc.
- Home Page (find us at <http://www.adavb.com.au>)

INFORMATION & DISPUTE RESOLUTION SERVICES

The Branch provides information to the public on dental matters, and offers a conciliation service to assist patients to resolve disputes with member dentists. Information on treatments, facilities, dental issues and careers is available.



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