REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

INQUIRY INTO THE PROMOTION OF FALSE AND MISLEADING HEALTH-RELATED INFORMATION AND PRACTICES

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At Sydney on Tuesday 2 September 2014

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The Committee met at 9.45 a.m.

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PRESENT

Mr D. L. Page (Chair)

Legislative Council
The Hon. P. Green
The Hon. H. Westwood

Legislative Assembly
Mrs R. E. M. Sage (Deputy Chair)
Dr A. D. McDonald
Mr A. R. Rohan

CHAIR: The Committee on the Health Care Complaints Commission is holding hearings this morning in relation to its current inquiry into the promotion of false and misleading health-related information and practices. Today we will be hearing form Fair Trading NSW, NSW Health, the New South Wales branch of the Australian Medical Association and, lastly, Civil Liberties Australia via teleconference. For the benefit of the gallery I note that the Committee has resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines governing coverage of proceedings are available on the table by the entrance to this room. I now declare the hearing open.

RODNEY STOWE, Commissioner, Fair Trading NSW, and

PHILIP MATHEW FLOGEL, Assistant Commissioner, Fair Trading NSW, sworn and examined:

CHAIR: I welcome Mr Rod Stowe, Commissioner, and Mr Philip Flogel, Assistant Commissioner, Fair Trading NSW. Thank you for appearing before the Committee on the Health Care Complaints Commission today to give evidence. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses, and do you have any questions about that information?

Mr STOWE: No we do not.

Mr FLOGEL: No I do not.

CHAIR: Would you like to make a short opening statement before questions commence?

Mr STOWE: No, thank you Mr Chair. You will note we have made a submission to the Committee. We will rest with that, thanks.

CHAIR: Has there been a noticeable increase in recent times in the number of traders of health-related products or practices that have been investigated by Fair Trading for making misleading or deceptive claims?

Mr STOWE: I would suggest it has probably been fairly static over a number of years. However, Mr Flogel might be able to give you a bit of an indication of what we have undertaken in the last couple of years.

Mr FLOGEL: Currently, we have three matters under investigation. It is not a large proportion of the work Fair Trading receives, and it is quite a small amount of complaints in that particular area that we receive over the course of a year.

CHAIR: Can you tell us what type of investigations those three areas cover?

Mr FLOGEL: Yes, certainly. We have one complaint matter that relates to complaints about, I guess, alternative medicine with regard to healing therapies. We have looked at this particular matter and it is based in Australia but also has a connection with an organisation overseas in the United States. We reviewed their web page following some complaints and asked the Australian trader to verify various claims they made with regards to cures to particular therapies. As a result of issuing a substantiation notice, they decided to remove certain claims from the Australian website. However, the American website, which was also asked to remove those claims unless they could verify them to us, continues to publish those claims. Of course, we do not have the jurisdiction to take any further action with that particular overseas jurisdiction.

There is another matter we are currently looking at with regards to therapies related to the use of certain laser treatments that have caused some scarring. That is a matter that is currently under investigation. There are also issues with regard to lack of customers to actually get back and have some of their questions answered with regards to the overall customer service as well. The third matter, which is also under complaints—very similar to the first one I outlined, except it is early in the investigation—again relates to alternative-type medicine where certain therapies are provided. We are looking very carefully, particularly from the Australian Consumer Law [ACL] perspective, with regards to whether any of the claims that are made may be false or misleading to consumers and affecting consumers in that way.

CHAIR: As I understand it, Fair Trading can investigate only where services or products are purchased as opposed to given for free, is that correct?

Mr STOWE: It has to be in trade and commerce.

CHAIR: If someone were to make available certain products or services as part of a giveaway weekend or something similar but did not charge for it specifically, would that mean that that particular offering is outside your jurisdiction and, therefore, you could not investigate it?

Mr STOWE: There has to be a contractual relationship under the Australian Consumer Law and it governs the acquisition of goods and services by consumers in trade and commerce. We would need to establish that the business was trading for us to be able to take action under the legislation. Sometimes inducements can be provided—free gifts and services—however there usually is some other contractual arrangement between the business and the consumer, which will allow us to intervene. But if there is no provision of services where there is payment, where there is not a trade relationship, then it would be problematic for us to be involved.

Mr FLOGEL: The only exception might be under the Incorporated Associations Act, as we have outlined in our submission, where information might be provided, for example, for free there. Then we have some limited powers to take action with regards to changing the name of that incorporated association if we felt that it was inappropriately named and represented, which we have done in recent times.

Mrs ROZA SAGE: The Australian Vaccination Network [AVN] was the subject of a high-profile investigation by Fair Trading, which was of particular interest to this Committee. Are there any other current investigations by Fair Trading that concern health-related products or services that would be of similar interest?

Mr STOWE: Other than what Assistant Commissioner Flogel has said, there are no other investigations underway. We certainly are not investigating AVN.

Mrs ROZA SAGE: Are there any other organisations that have come under your radar?

Mr STOWE: No.

Mr FLOGEL: No.

The Hon. PAUL GREEN: In your submission you advise that Fair Trading and the Health Care Complaints Commission [HCCC] are able to enter into arrangements to share information jointly and investigate matters where there is overlapping of jurisdiction and common issues. How many times, if ever, has this arrangement been entered into?

Mr STOWE: I would have to take that on notice. I am happy to provide it. We do have a memorandum of understanding with the Health Care Complaints Commission. In my experience, we certainly have dealt with them and cooperated with them on matters, but in terms of the number I would have to check and happily provide it to the Committee.

The Hon. PAUL GREEN: Could you give an indication of the type of collaboration and topic?

Mr STOWE: Sure.

Mr ANDREW ROHAN: Your submission refers also to strengthening information-sharing arrangements between Fair Trading and the HCCC. This view has been echoed by other stakeholders that spoke of the need of an interagency commission to better coordinate and enter investigations. What sort of information would be most useful to share between your organisations?

Mr STOWE: I think it might be helpful for the Committee to understand that Fair Trading has quite a wide remit when it comes to the Australian Consumer Law. The laws we administer generally affect conduct in the marketplace. We have limited resources and when it comes to health-related complaints about goods or services, the way in which we often investigate that is to try to substantiate the claims being made by the business.

One of the difficulties we have is being able to actually prove or disprove the information that is provided to us to substantiate those claims. Quite often it needs scientific analysis. We often do not have the expertise within Fair Trading to look at these health-related matters; we need to employ experts elsewhere and that is a costly and quite often time-consuming piece of work. One of the things that would be helpful would be to be able to employ the expertise that resides within the health care complaints area and generally the Department of Health to assist with some of that work.

Mr FLOGEL: We do share information when there has been a specific case and there have been determinations then as to which role we would play in that. In a matter that we have dealt with in more recent times—a matter that has been led by the Health Care Commission and is still under inquiry and investigation by them as I understand it—we have worked somewhat collaboratively in assessing and working through those

issues that the Health Care Commission is looking at and the Australian Consumer Law issues relevant to our jurisdiction.

Mr ANDREW ROHAN: Is there scope for an interagency committee being established for ongoing dialogue concerning matters of overlapping jurisdictions?

Mr STOWE: That would obviously be a question for government and government policy but we would certainly be interested in any further collaboration that can occur between agencies that have this overlapping responsibility. We do have bilateral discussions with the Department of Health and we have memorandums of understanding but we are always interested in better cooperation and better outcomes that can be achieved through that sort of work.

Mr ANDREW ROHAN: In what other ways could Fair Trading and the Health Care Complaints Commission [HCCC] improve the way they work together?

Mr STOWE: I think it is in that area of expertise that would be helpful. As I say, within Fair Trading we do not have people with the sort of analytical skills that are quite often necessary to examine some of the claims that are made by health-related businesses and services. I think that is an area where we would certainly appreciate the assistance of the Health Care Complaints Commission and generally the Department of Health.

Mrs ROZA SAGE: Would you refer anything that you think is a difficult healthcare-related matter to the HCCC or would you look at it yourself? What sorts of decision do you make about what matters you will look at and what matters you will refer to the HCCC, and do you refer them?

Mr STOWE: We certainly do refer them, and quite often that is at the very early stages. Mr Flogel has talked about some of the investigations we have undertaken. But when complaints come to Fair Trading they are dealt with by our customer services staff. They are able to refer matters which are more appropriately within the remit of the Health Care Complaints Commission quite early in the piece before we get anywhere near an investigation. That does happen on a daily basis. We have good liaison with the Health Care Complaints Commission. It is really when we have escalated matters which relate to breaches of legislation that we need to make a decision as to whether or not we use our investigative resources or we make a reference to the Commission or we look to cooperate in the way in which we investigate a matter.

Dr ANDREW McDONALD: My question is about your remit in relation to secondary advertising medicines, questionable labelling and stem cells. We will start with secondary advertising medicines. There has been a tendency for drug companies over the past few years to advertise directly to the market and say, "Speak to your GP about your dyspepsia", for example. What remit do you have in controlling that? The evidence for some of those drugs is that they are no better than the ones currently around. An example is for gastritis you can use a cheap drug or an expensive drug and it is the expensive drug that is doing the marketing.

Mr FLOGEL: I think those sorts of questions would not necessarily be something that we would investigate. I would in my role defer back to Health to have a look at that particular issue under the Therapeutic Goods Administration Act to make a decision as to whether the drugs you are referring to are appropriate for their medicinal purpose.

Dr ANDREW McDONALD: They are appropriate, they are just expensive. It is a marketing tool to get doctors to change from the less expensive to the more expensive and slightly different product. They are both equally effective. One is a lot more expensive to all of us and no more effective. Would an individual patient or practitioner complaint to you trigger such an investigation or would that not change what you would be inclined to do?

Mr FLOGEL: It might be a matter that could come to our customer service division and they would make a decision at that point as to whether it is a matter where they could in fact resolve the dispute between the consumer and the trader.

Dr ANDREW McDONALD: It is usually stopping the drug company from advertising their product direct to the public, which is what it is all about. Rather than selling a dodgy product they are selling a highly expensive product that works.

Mr STOWE: We would have to make an assessment as to whether we felt it was a blatant breach of the Australian Consumer Law [ACL] or whether it was puffery. There is a fair bit of latitude that we have. We have got complete discretion as to what we decide to examine. We have also got a compliance and enforcement policy that sets for us some priorities as to what matters we will look into. That relates to the vulnerability of consumers and the amount of consumer detriment. All those elements are taken into account when we determine whether we use our finite investigative resources. Because the Australian Consumer Law is not only administered by Fair Trading NSW but by all the States and Territories and the Commonwealth we also regularly work with the other agencies to determine whether it is something that they might have an interest in. Of course, anything that has a national aspect would be something that the Australian Competition and Consumer Commission [ACCC] is more likely to take on than us.

Dr ANDREW McDONALD: The second part of my question is about the use of common drugs such as paracetamol being marketed as "so and so osteo" and there being a considerable mark-up on the packet. Have you had any complaints about that and would that be also in your remit?

Mr STOWE: I would have to take that on notice. I am not aware of any complaints of that sort. I know that Choice, the consumer movement, has made representations about that sort of advertising but we certainly have not had an official complaint from Choice. I would have to check for you in terms of complaints we have received. I am happy to take that on notice.

Dr ANDREW McDONALD: The final part of my question is about stem cells. I know a lot of these come from overseas but have you had any complaints about inappropriate or highly expensive stem cell therapy?

Mr FLOGEL: There is no matter that we are currently investigating. As to whether we have received complaints, we would have to take that question on notice and determine whether we have received any.

The Hon. HELEN WESTWOOD: I will ask some follow-up questions around the Australian Vaccination Network [AVN], which you referred to earlier. In your submission you say that because it was an incorporated association you were able to take action. If such an organisation existed that was not an incorporated association but gave free advice or if a client did not purchase anything from it would you be able to take action?

Mr STOWE: I do not believe so. As I made the point earlier, under the Australian Consumer Law there needs to be a contractual arrangement between a consumer and a business and the business needs to be in trade and commerce. They would need to be trading in some way for us to take action. If they are just a website providing free advice and information, notwithstanding that people may challenge the veracity of that information, it is not something that we would normally be able to intervene in. In the case of the association, we were able to take action because we formed the view that the name breached the legislation and was misleading. As you would be aware, we were successful when that was appealed.

The Hon. HELEN WESTWOOD: The process for that organisation to change its name was to be completed by March of this year. Are you satisfied that they have done that?

Mr STOWE: We are. We have had a very close look at their website and satisfied ourselves that they have changed their name. There are some historic references to the old name but we think that is appropriate given that it is historical in nature. I am certainly aware that there have been some allegations that in other communications the old name has been used. When we have had a close look at those it has not been demonstrated to us that it is the association itself that has been responsible for making those statements about the name of the organisation.

The Hon. HELEN WESTWOOD: One of the concerns brought to the attention of the Committee is that Fair Trading has a broader range of coverage to be able to investigate complaints and more powers at its disposal than the Health Care Complaints Commission. In this respect, many complaints have been lodged with Fair Trading that may otherwise have been lodged with the Health Care Complaints Commission. How many cases has Fair Trading investigated that relate to the promotion of a health-related product or service that is misleading or deceptive?

Mr STOWE: I will have to take that on notice. What period are you interested in?

The Hon. HELEN WESTWOOD: Two years.

Mr STOWE: We will do that.

The Hon. HELEN WESTWOOD: Do you believe that any or all of these cases would have been better investigated by the Health Care Complaints Commission given its exclusive focus on healthcare complaints?

Mr STOWE: Again, we would have to look at those matters. I can use the analogy of the food regulator. As we have discussed, Fair Trading has a broad remit in relation to marketplace activity. In early years we would involve ourselves in issues of false and misleading claims in relation to food. We now have the NSW Food Authority, which is a specialist regulator. It has powers very similar to ours and we do not step into an area where there is a specialist regulator. We no longer get involved in many of those claims about false and misleading food matters. It is a parallel situation in the health area in that the Health Care Complaints Commission has some ability to deal with those matters, but more could be done to strengthen its role as the specialist regulator. As you say, we have a broad remit but, of course, we have limited resources and expertise to be able to delve into every complaint we receive about a health-related service or provider.

Dr ANDREW McDONALD: Would legislative change be required or is it done by the Government?

Mr STOWE: Any legislative change is a matter of government policy, so I would not want to comment. It is an area that could be further explored and our submission indicates that it is something the Committee could consider.

The Hon. HELEN WESTWOOD: What are some of the powers Fair Trading may typically use if it finds that a health-related product or service claim is misleading or deceptive?

Mr FLOGEL: We can consider a broad range of options when we wish to take action against a trader. We look at the actual extent of the complaint, the extent of consumer detriment, and the nature of the matter itself on a case-by-case basis. As I indicated earlier, we looked at a matter earlier this year involving various claims made on a website and we issued a substantiation notice. The trader then removed those claims from the website. We are satisfied that that was a good outcome for consumers. With more serious breaches, and particularly with regard to false and misleading information, we determine how we might prosecute someone under the Australian Consumer Law. We look at the range of issues involved to determine what action we will take—for example, the number of complaints received, the behaviour of the trader, and whether it is some sort of genuine mistake, such as a customer service issue, or an ongoing and indiscriminate abuse of the law. They are the determinants with regard to how we take action. Our level of action can range from a warning all the way up to taking legal action in the Supreme Court if necessary, and we have done that in the past.

The Hon. PAUL GREEN: On a lighter note, at point 5.4 your submission mentions that you prosecuted a hair regrowth trader for misleading consumers. Does that mean there is someone who can actually regrow hair? If so, where are they?

Mr FLOGEL: That was the claim.

Mr STOWE: That was an interesting case because the action related to false information given to the tribunal about the qualifications of the individual promoting the product.

The Hon. PAUL GREEN: You spoke briefly about legislative changes. Obviously this inquiry is trying to strengthen the legislation to prevent people using loopholes. What can this inquiry do to close some of the loopholes?

Mr STOWE: Our submission states:

> Section 26 of the Health Care Complaints Act provides that the Commission may refer a complaint to any person or body if it appears that the complaint raises issues which require investigation by that person or body. The scope of this section is narrower than the provisions under the Fair Trading Act as a complaint must first be established under section 7 (1) (b) of the Health Care Complaints Act.

That has occurred. The legislation contains a qualification that could be examined to determine whether it needs to be retained.

Dr ANDREW McDONALD: What is the current law in respect of medical professionals advertising their services? Are they allowed to advertise? Does any advertisement have to be factual?

Mr STOWE: There is no legislation that we are responsible for that relates specifically to the medical field. Again, the Australian Consumer Law applies. If any claims made by a business are false, misleading or deceptive then we have a role in taking that business to task or intervening. That intervention may range from a warning through to prosecution. We have that broad ability. I cannot say what specific requirements relate to the health profession. Some relate to professional standards imposed by the bodies to which health professionals belong. However, that is outside the purview of the Australian Consumer Law.

Dr ANDREW McDONALD: Was your office involved in the prosecution of the company advertising that it could ensure longer-lasting sex?

Mr STOWE: We were involved in one of those matters with the Australian Competition and Consumer Commission and perhaps Mr Flogel can provide more information.

Mr FLOGEL: It predates my time at Fair Trading.

Mr STOWE: We were involved in one of those matters. We commenced the action, but it was ultimately taken over by the Australian Competition and Consumer Commission. We assisted in its investigation, but we were not responsible for taking the matter through the courts. I am happy to supply more information about that.

Dr ANDREW McDONALD: That would be good.

CHAIR: I want to drill down on the powers you have compared to those of the Health Care Complaints Commission. Your powers are broader and stronger. When you research the number of complaints Fair Trading has received can you also inform the Committee how many complaints have been referred by you to the Health Care Complaints Commission and also by the Commission back to you?

Mr STOWE: Yes.

CHAIR: In that context, do you believe Fair Trading, the Health Care Complaints Commission and the Therapeutic Goods Administration have sufficient legislative tools to ensure that people or organisations promoting harmful misinformation can be dealt with properly, or do you think there are gaps in the legislation?

Mr FLOGEL: When a complaint is made to us we go through the assessment process and determine whether Fair Trading needs to be involved. The Therapeutic Goods Administration Act provides that investigations can be conducted. I am aware that the Act is under review at the moment. I guess it is best left to Health NSW to comment on whether additional powers and processes could be provided with regard to therapeutic goods in respect of that Act.

Mrs ROZA SAGE: How would you determine whether a medical or health-related claim is false or misleading? Does it stem from complaints or do you look generally as well?

Mr STOWE: It is mostly as a result of complaints that come to our attention.

CHAIR: So it is a reactive regime?

Mr STOWE: We have responsibility for some specifically regulated industries and we do a lot of proactive work in the marketplace to ensure they are compliant with our legislation. However, as I said, we have finite resources. Health-related investigations are mostly in response to consumer complaints made to the agency.

CHAIR: I refer again to Fair Trading's powers being stronger than the Health Care Complaints Commission's powers. When you have discussions with the Commission about who should handle a complaint, presumably that issue becomes a factor in the decision. In other words, a matter might seem serious enough to warrant the use of your powers as opposed to being dealt with by the Commission, which does not have those

powers. It may be difficult to say from Fair Trading's point of view, but do you think the Health Care Complaints Commission needs stronger powers and enforcement powers?

Mr STOWE: Again, it is difficult for us to comment on that; it is a government policy matter.

CHAIR: Presumably who has the power to deal with something comes up in your discussions with the Health Care Complaints Commission?

Mr STOWE: Most certainly. That is an important part of any of that work; we need to understand where our responsibilities start and finish and where the agency is able to deal with those matters. Jurisdictional issues are important when it comes to those discussions.

The Hon. HELEN WESTWOOD: You made a comparison earlier with the Food Authority. Is this a similar situation? If the Government gave the Health Care Complaints Commission more powers would you then pull away from that role?

Mr STOWE: There is some utility in having specialist regulators. That means that an organisation like ours, which has a very broad remit, would be able to allocate its resources where they need to be, which is often with the regulated industries that government has asked us to watch closely, as well as the broad marketplace. If there were to be greater specialisation in terms of health regulation, it would mean that we would not need to have that overlapping activity. As I said, I think it has been well addressed in the food area, which has very similar powers, and that has happened over time. The Food Authority has now replicated Fair Trading and that means we do not have to delve into that area as much as we did in the past.

The Hon. PAUL GREEN: Has Fair Trading done anything in response to the current media debate about cannabis and cannabis oil use?

Mr STOWE: No, we have not.

Mr ANDREW ROHAN: You have indicated that you have a broad marketplace but limited resources. Have you asked the Department for more resources or more powers?

Mr STOWE: I do not think there would be any agency head who at one time or another had not indicated the need for greater resources. We certainly operate within the current budgetary context and we use the resources we have as effectively and as efficiently as we can. We draw to the Government's attention any improvements that need to be made to the legislation. However, when it comes to the Australian Consumer Law we no longer have the autonomy we once had. Those decisions must now be made collectively with other governments. For instance, it is not quite as easy as it was to make a change to the Fair Trading Act. We need to get the support of other jurisdictions to make those changes. That process is underway now in relation to the Australian Consumer Law. A major review of that legislation will be undertaken in 2016 and we will be examining it much more closely to determine whether it has been as effective as we hoped it would be when we instigated it couple of years ago.

CHAIR: Thank you for appearing before the Committee today. The Committee may wish to send some supplementary questions in writing, the replies to which will form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

Mr STOWE: Most certainly.

CHAIR: Thank you again for appearing before the Committee today. We appreciate your time.

Mr FLOGEL: Thank you.

Mr STOWE: Thank you.

(The witnesses withdrew)

JEREMY McANULTY, Director, Centre for Health Protection, NSW Ministry of Health, sworn and examined:

CHAIR: I welcome Dr Jeremy McAnulty, Director, Centre for Health Protection, NSW Ministry of Health, appearing before the Committee today to give evidence. Can you please confirm that you have been issued with the Committee's terms of reference and with information about the standing orders that relate to the examination of witnesses?

Dr McANULTY: I have.

CHAIR: Do you have any questions about that information?

Dr McANULTY: No.

CHAIR: Would you like to make a short opening statement before the commencement of questions?

Dr McANULTY: In NSW Health we made a submission relating to the anti-vaccination information provided primarily by groups such as the Australian Vaccination-skeptics Network [AVN]. We are concerned that information of that nature is false and misleading and can lead parents to false beliefs about the risks and benefits of vaccination and lead to parents making decisions not to vaccinate. When children are not vaccinated, that runs a risk to the whole community of vaccine-preventable diseases taking off and causing outbreaks and epidemics. Our aim in NSW Health and as a community is to maximise vaccination rates so that we can have the best possible protection in the community from dangerous diseases.

What we see in New South Wales is variations in vaccination rates across the State. On the North Coast, for example, there are areas of low coverage compared to other parts of the State and we are concerned that we need to maximise those rates, to get the best possible protection. We support the Health Care Complaints Commission [HCCC] in protecting public health and safety through dealing with complaints about health providers and health services. In 2009 the Health Care Complaints Commission received two complaints alleging that the AVN engaged in misleading and deceptive conduct to dissuade people from being vaccinated and from having their children vaccinated. The HCCC issued a public warning. In 2012 you will be aware that the Supreme Court determined that the Health Care Complaints Act only granted the Health Care Complaints Commission the power to investigate complaints where the health service in question affects the clinical management and the individual client.

Subsequently, the Health Care Complaints Act was amended as part of the Health Legislation Amendment Act 2013, to make it clear that the Health Care Complaints Commission can assess, investigate and prosecute complaints about health services that affect or are likely to affect the clinical management of the care of an individual client. We support the intent of that amendment to develop the capacity of the HCCC to investigate complaints against organisations such as the AVN that can impact on public health. While we consider it is likely that this amendment will support the HCCC to investigate and take enforcement action in these circumstances, it is noted that these have not been tested in the court and so it needs monitoring over time.

CHAIR: I ask the first question in relation to the low rate of vaccination. Coming from the North Coast, I am more than familiar with that problem. In Mullumbimby it is as low as 50 per cent, which is way too low. However, as you recall, the Government made some changes in relation to the requirement for conscientious objectors to see a general practitioner [GP] prior to enrolling their children at preschool. Has there been any improvement in the vaccination rate as a result of that measure?

Dr McANULTY: We are awaiting data from the Australian Child Immunisation Register to confirm that. Anecdotally, we have had reports of an impact locally, with childcare centres having good interactions with parents who are providing the certificates that are now required to their childcare centres before enrolment.

CHAIR: You have done a lot of work on the AVN issue but are you aware of any other group or individuals promoting similar kinds of misinformation to actively discourage individuals accepting established healthcare practices?

Dr McANULTY: The AVN is the most prominent in Australia. If you look on the internet you will find a range of resources but no single group has been as prominent, in our experience, as the AVN.

Mrs ROZA SAGE: Are there any other groups that have been brought to your attention that might be of concern?

Dr McANULTY: If you look on the internet, there is a range of groups. I do not have particular names of any that have been prominent in my recall.

The Hon. PAUL GREEN: Do we have statistics in these lower-use areas that there is an increased outbreak of these conditions?

Dr McANULTY: Certainly we have had. It is hard to scientifically draw a definite correlation between misinformation and therefore low vaccination rates and outbreaks. But certainly we have seen outbreaks of whooping cough and measles on the North Coast associated with areas of lower vaccination. Biologically we know that vaccination protects against these diseases. So when you get communities with low vaccination rates you get both the individual at risk but also the more individuals who are not vaccinated you get lower herd immunity and, therefore, it increases substantially the risk that epidemics will take off and be sustained. We see an effect of that and that is why we are pushing immunisation.

Mrs ROZA SAGE: With changes to the Health Care Complaints Act in 2013, it now provides that the Health Care Complaints Commission [HCCC] can access, investigate and prosecute complaints against health services that affect—or are "likely to affect" now are the new words in the Act—the clinical management or care of an individual client. With the exception of the AVN, are there any other groups or individuals that you think the HCCC can now investigate where they were not able to do this before the changes?

Dr McANULTY: I am not aware of specific groups of which complaints have been made or that we are aware of being particularly prominent. I think this new legislation, should they become aware or receive complaints about other such organisations, will allow investigations to be held by the HCCC.

Mrs ROZA SAGE: I was specifically thinking about the anti-fluoridation people. Have they been on your radar or of concern to you?

Dr McANULTY: Our approach for both immunisation and fluoridation has been to push out accurate information so that the community has access to those things. One of the concerns about the AVN was that when a parent Googled "immunisation information", it would come up on the top of the Google search. It was not obvious from the name of the organisation that it was, in fact, anti-vaccination. That perhaps influenced an individual's decision.

Fluoridation is different in that certainly we have engaged strongly with fluoridation and promoted the benefits of fluoridation—which are clear—with local councils. It is not a clinical decision about whether an individual drinks water that is fluoridated or not; it becomes a community and council decision. So rather than working with an individual making an individual decision, we work with the communities and councils. For example, the Chief Health Officer went up to the North Coast a couple of times last year to talk with local councils and communities. So we believe the issues are slightly different in terms of clinical decisions that affect an individual's decision for themselves or their child to get vaccinated versus a broader debate about the risks and benefits of intervention on a population, such as fluoridation.

Mr ANDREW ROHAN: With the scientific information that you have, all this scientific data that you have to prove that these skeptic organisations or individuals are really promoting their own cause, how is it that while you have scientific proof people still believe in those skeptics, whether it is vaccination, fluoridation or something else?

Dr McANULTY: That is a good question and I cannot answer that. Some people have anti-scientific views, conspiracy views and a whole range of issues that feed into that. There has been research looking at reasons why parents do not get a child vaccinated or delay the vaccination of a child. That is something we are trying to address. When you look at the registration of people who are conscientious objectors, it is quite a small percentage, of the order of 1 or 2 per cent, in communities across New South Wales. The biggest problem is parents not making immunisation a priority because they do not necessarily see the adverse effects of diseases like polio, because of the impact vaccination has had.

Mr ANDREW ROHAN: Just 1 or 2 two per cent of the population—a minority. Do you find in future years that they are more prone to diseases? Can we prove that or is it just averages, like any other population?

Dr McANULTY: We certainly do have very good evidence that unvaccinated children and adults are at much increased risk of getting diseases against which they are not vaccinated. For example, we have had measles epidemics in the last couple of years and they have overwhelmingly affected under-immunised children and adults.

Mr ANDREW ROHAN: And still their parents would not accept that?

Dr McANULTY: It is interesting that when, in an attempt to control outbreaks of diseases such as measles, we offer free clinics at schools sometimes you do see, in the face of an immediate threat, people changing their minds and getting children vaccinated, which is heartening.

The Hon. PAUL GREEN: The HCCC has the power to issue a public health warning under section 94A but only once the investigation is finalised; there is no scope for the HCCC to make interim warnings while an investigation is on foot. Is an amendment to the Act to allow the HCCC to make interim orders something NSW Health would consider?

Dr McANULTY: It has not been on our agenda. We would be interested in the outcome of your deliberations, but at the moment we try to counter the false information out there. We had a campaign promoting immunisation last year and we are about to do another one. There is always going to be a range of views in the community. We see our role in government is to promote scientifically based views so that parents have the best information available to them.

CHAIR: I ask a question in relation to the definition of "health service". In its submission, the HCCC stated the definition of a "health service" under its enabling Act is an exhaustive list of specific health services that may not cover some of the health-related information and services canvassed by this inquiry. By way of comparison, the Queensland Health Ombudsman Act is significantly broader in scope in its shift away from specifying occupational-based health services to more generic descriptions of what a health service may entail. Is a similar change to the definition of "health service" by a specific list of health-based services to a generic catch-all something NSW Health would consider?

Dr McANULTY: My understanding is that our definition gives examples as included and then lists them. But I can take that on notice. I am not a legal expert.

CHAIR: It does come up in quite a few submissions and it is painted as a constraining influence. It is an exhaustive list and if you are not on the list then you cannot be investigated. Whereas in Queensland, I think the Commonwealth has broader, more generic powers which enable the Health Care Complaints Commission to look at things that are in a grey area. If you could do that, it would be great.

Dr ANDREW McDONALD: Moving on from Mr Chair's question. One of the things that people advertise is cancer treatments. Has NSW Health found people advertising cures for cancer to be an issue?

Dr McANULTY: I am not aware that we have been engaged in that, but I can take that on notice and get back to you about the issue. It is outside my particular domain of health protection.

Dr ANDREW McDONALD: The same thing applies to stem cells, which is also being advertised. Has that come under NSW Health's—

Dr McANULTY: Not in my experience, but I can get back to the Committee with an answer to that.

Dr ANDREW McDONALD: Vaccine side effects: you know about the influenza CSL 1 vaccine, and the meningococcal type B vaccine does not look like it is going to be approved because of questions about efficacy. How does NSW Health deal with this sort of issue?

Dr McANULTY: We look at the evidence scientifically and whether there are adverse events from the vaccine, including flu. We gather the scientific data, we go to our health services, and we may initiate special studies. Our approach is then to gather the data and seek expert advice to help mull over that data to interpret what the implications for public health would be in relationship with the appropriate regulator—so in the case of

flu vaccine, the TGA. There is a national structure through chief health officers and communicable disease experts to assess information and then develop some policy and implement that policy. They are fairly robust systems that are tried and true through several examples such as the ones you mentioned.

Dr ANDREW McDONALD: Moving on to the complexity of flu immunisation, we have a system where now, I understand, we are recommending it for adults at risk, such as health workers. But most of the children who got the side effects from that CSL flu vaccine should probably not have been immunised because they were not in the groups for which immunisation is recommended. For the record, what are the current recommendations for childhood flu immunisation?

Dr McANULTY: One recommendation is that anybody over six months who wants to avoid the flu can get the flu shot because it is effective. But it is particularly targeted for groups at an increased risk of complications, and they include pregnant women, the elderly and people with underlying medical conditions such as chest, heart, diabetes and so on. The context is that the flu does kill hundreds of people around Australia every year and hospitalises thousands, so it is a really big deal. We learnt, particularly during the pandemic, that pregnant women, for example, are one of the higher risk groups. So trying to encourage those groups particularly to get vaccinated is a very important public health message. But we also need to be very transparent about side effects. It has been heartening to see that the process worked when the recognition of adverse incidents in children was recognised and regulatory action was taken.

Dr ANDREW McDONALD: Just for the record, the problem with the CSL flu vaccine was—

Dr McANULTY: In children under five there was a higher than expected rate of febrile convulsions subsequent to being more antigenic; so more fever was seen in children than expected.

Dr ANDREW McDONALD: Was it just simple febrile convulsions or were there long-term sequelae in some of those children?

Dr McANULTY: The population studies suggest it was febrile convulsions related to the fever. I am aware that there was a case in Western Australia that was investigated but I do not have more details on that.

The Hon. PAUL GREEN: Did any of those febrile convulsions go on to debilitating or fatal circumstances?

Dr McANULTY: I can only talk of New South Wales. I am not aware of cases where—

The Hon. PAUL GREEN: That comes to the other thing about the education program about the flu. We talk about the flu vaccine but there are hundreds of different levels of flu. I guess the community hears that there is a flu vaccine and they think they have been covered for all those types but they have not, have they?

Dr McANULTY: Every year there is a process where scientists look at what flu strains are likely to be floating around. So the flu vaccine contains the three most likely strains and usually, not always—

The Hon. PAUL GREEN: But they change every year, do they not?

Dr McANULTY: They can change every year, but not always. It is kind of a game to match the best scientific information, and usually that is pretty good but not always. Sometimes there is a not a complete match and that can lead to not as complete coverage and protection from the flu vaccine. But the flu vaccine is the best thing we have got to prevent this often deadly disease.

The Hon. PAUL GREEN: Have there been studies as to the likely outcome if we did not give those vaccines as opposed to having those vaccines? Has there been some sort of rough estimate of the impact of not giving those?

Dr McANULTY: We do know that the vaccine has a certain efficacy or protective factor in the community. That is, again, depending on the match of the season and the particular vaccine that has been tailored for that season can vary—and this is a guestimate—around 50 to 80 per cent, depending on the background healthiness of the person. So in young and healthy people it tends to be more effective than in the elderly.

The Hon. HELEN WESTWOOD: The HCCC suggested that consideration could also be given to broaden the current power to have public warnings include warnings about particular individuals who are not themselves health providers, as well as unethical services. What is NSW Health's view of that proposal?

Dr McANULTY: I guess it comes back to the definition of what "a health service" is. As I understand it, groups like the AVN are captured under the definition of "a health service". Further detail I would have to take on notice to get back to you.

The Hon. HELEN WESTWOOD: If you would not mind taking that on notice.

CHAIR: Can I ask a question in relation to powers? Whilst the HCCC can do an investigation, its legal capacity to take action is quite limited. The Commission can make comments or recommendations but compliance with these is voluntary. That seems to me to be a fairly major flaw in the legislation if, having done the investigation—putting aside for the moment whether they can issue interim warnings and whatever upfront—and they make a recommendation, there is no power there and, from what I can understand, the compliance is voluntary. Tell me if I am wrong. An offender does not have to comply with what the HCCC is recommending. Is that your understanding of it?

Dr McANULTY: I am not across the detail on that as to whether it is voluntary.

CHAIR: Could you have a look at that for me please, because if that is true, and I believe it is, I think it is a major issue that we need to be looking at?

Dr McANULTY: I guess a point to make is that we do work across, for example, in the AVN example, Fair Trading, the Office of Liquor, Gaming and Racing as well as HCCC, and we have looked at different aspects of it. Fair Trading are able to put an enforcement notice on the website of the AVN looking at a change of name. The Office of Liquor, Gaming and Racing were looking at the charitable status. So there was an across-government approach to this problem.

Mrs ROZA SAGE: Following on from that last answer, there have been some suggestions about establishing an interagency committee—you were describing how you work together—between all the bodies responsible for protecting consumer health. What are your views on the establishment of such a committee?

Dr McANULTY: We already meet with Fair Trading, for example, and the NSW Food Authority and other regulators such as the Department of Primary Industry on specific issues that come up to both help understand and collaborate on the issues and identify grey areas. That seems to be an effective way. So we aim to and I think we are effective in developing that across-agency approach to get the best outcomes.

Mrs ROZA SAGE: Is that a formal process or is it more ad hoc?

Dr McANULTY: We have a formal agenda and we meet to discuss issues that each of us put on that agenda, and it occurs on a regular basis.

Mrs ROZA SAGE: Do you think there have been any gaps in oversight and protection?

Dr McANULTY: From my experience, when there is a grey area we have been able to discuss with one of those agencies, as I mentioned before, about the approach that we should take and whether it is a collaborative approach or it obviously belongs in one agency or the other. In my experience that seems to have been an effective approach.

CHAIR: Just following on from that, there has been a suggestion that the HCCC and Fair Trading be able to refer complaints to each other, enter into arrangements, share more information and conduct joint investigations. Is that something that NSW Health would support?

Dr McANULTY: We do not have any objection to it. We would probably need to have a look at the detail but it sounds like a sensible collaboration.

Dr ANDREW McDONALD: Looking at non-scientific practices, some of the medical insurance companies are now giving rebates for some of the therapies that have no great scientific basis. Has NSW Health had any complaints about people being involved in the industry?

Dr McANULTY: I am not aware of any, but, again, I would have to get back to you on that. I will take that on notice.

CHAIR: I thank you, Dr McAnulty, for appearing before the Committee today. The Committee may wish to send you supplementary questions in writing, replies to which will form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

Dr McANULTY: Yes.

CHAIR: Again, thank you for appearing before the Committee today; your evidence has been most helpful.

(The witness withdrew)

(Short adjournment)

SAXON DONALD SMITH, President, Australian Medical Association, affirmed and examined, and

ANDREW TOOK, Director, Medico-Legal and Employment Relations, Australian Medical Association, sworn and examined:

CHAIR: Thank you for appearing to give evidence before the Committee on the Health Care Complaints Commission [HCCC]. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses? Do you have any questions about that information?

Mr TOOK: No, we do not.

CHAIR: We have a submission from the HCCC that refers to the Queensland Ombudsman's legislation and the Commonwealth Privacy Act which provide broader definitions of health services than the current Health Care Complaints Act. You have similarly submitted that an extra subsection under the definition of health service would be appropriate. Why do you believe that the Health Care Complaints Act requires amending?

Dr SMITH: Firstly, we are concerned about the array of unregulated providers and organisations potentially preying on vulnerable members of our community. Ultimately we need to have the remit or terms of reference for the HCCC expanded beyond just a question of harm. We need it also to consider the capacity to safeguard the public from other issues around misleading and deceptive conduct, false or unsubstantiated claims and also false reassurance, and by "false reassurance" I mean people may have other high-risk factors which would not be identified, for the sake of argument, in a whole body scan. A patient would walk away thinking that they are all fine from cardiovascular risk or other risk and yet they are not.

CHAIR: I must apologise; I neglected to ask you whether you would like to make an opening statement. If you have something you would like to say by way of an opening statement, now would be a good opportunity.

Dr SMITH: No, that is all right. I was happy to go with the flow as well. Firstly, I welcome the Government's interest in this critical issue. Obviously we feel it is long overdue and of course has been a concern for some time. Critical to that is the concern around the array of unregulated providers and organisations that seem to fall through the gaps within the current provisions, be it in Fair Trading or the Health Care Complaints Commission. That means we are not necessarily protecting our community as best we could from those unsubstantiated claims, deceptive and misleading conduct, and particularly the false reassurance that people may gain from products or opportunities to intersect with these unregulated healthcare providers or organisations.

CHAIR: There are many organisations which currently provide health-related information that may be false, misleading or deceptive but which fall outside the jurisdiction of the HCCC. In your opinion what is the best avenue to take action against those organisations or people?

Dr SMITH: We believe that through the Health Care Complaints Commission a process allowing for a broadening of its scope of reference so that it can capture those organisations and providers as stated will be very important. Within that, having the capacity to perhaps have a warning register under section 94A would be a very simple, cost-effective start; and then, importantly, taking it away from the more direct harm to the public but also to those harms to the public that may be due to ineffective and unscientific and liable to deflect the public from seeking effective evidence-based medical care.

CHAIR: Do you have any comments, Mr Took?

Mr TOOK: No. I think the amendments we have suggested go to certainty rather than specificity. There is some doubt or some concern about how you read the amendments and we believe that the inclusion of terms such as health service provider and/or organisations would give certainty to the HCCC to commence an investigation, if required.

CHAIR: One of the things that concerns me about the HCCC as it currently stands is that whilst it can do investigations and make recommendations there is no compulsion in relation to compliance. Do you share that concern?

Dr SMITH: If I may by example look at the prolonged concern we have had around the Australian Vaccination Network, which has now been rebranded. When we first brought this to the attention of the various State departments, which included the HCCC and also the Fair Trading Commission, they felt that under none of their specific scope of remit were they actually able to action anything. It took a process of legislation to allow action to be taken in this space where a lot of misleading information was being provided to our community and also repeated sanctions of that organisation before things were changed. If that is the process you have to go through for one organisation, it is not something that people will willingly engage with. So to have it stated in that clarification through the definitions and terms of reference would be really important to allow that capacity and teeth in action.

Mrs ROZA SAGE: Does the Australian Medical Association [AMA] do any work to combat or refute misinformation that is available in the public domain and, if so, what do you do?

Dr SMITH: By way of another example, one of the actions we have been working through with our organisation and on behalf of our members is the providers of the full body scanners. These are companies essentially that will scan you from head to toe with often a CT scan looking for evidence of cardiovascular calcification, cancer and the like. They often advertise through senior cards membership lists. Unfortunately our intersection with it is our patients approach our general practitioner [GP] members bringing this to the attention of their GP and asking, "Should I be doing this?"

At no point does the information provide a risk stratifying the patient accordingly, nor does it acknowledge the fact that there are false negative rates in doing any kind of test. Importantly, it also fragments care because it is not part of the role in that the investigation is not being performed in the construct of the whole person's health through their general practitioner or treating specialist, which is coordinating for all the other issues that they might be having. This is something that has been brought to the attention of the HCCC and also the Fair Trading Commission and we receive repeated letters sending back, telling us to respond to the other one, as in the other organisation. So a game of ping-pong has ensued and yet we still do not have an outcome which is necessary for those vulnerable members of our society.

The Hon. PAUL GREEN: In that arena, if something is identified, do they have their own avenues to refer that person on or do they refer them back to the person's GP?

Dr SMITH: That is a very good question.

The Hon. PAUL GREEN: Thank you.

Dr SMITH: The issue is that each unregulated organisation that is offering this service firstly does not necessarily intersect it back with the general practitioner. As I said, they are set up as a stand-alone entity to provide an element of false hope or false clearance potentially; some may offer the opportunity to intersect back with GPs but frequently not.

The Hon. PAUL GREEN: But there is no requirement for it.

Dr SMITH: Absolutely no requirement, as they are standalone entities, again fragmenting the care of patients in our community.

The Hon. PAUL GREEN: Do we have any statistics about the implications of that model?

Dr SMITH: The issue with it is that they stand outside normal regulation. Therefore, you do not have access to statistics; you do not know what their capture rate for anything significant is; you do not know what their capture rate is for missing things that are significant as well. It is a black box.

Mrs ROZA SAGE: Just to clarify, you are saying that the powers of the HCCC should have a much broader scope to encompass all those sorts of organisations that are not already regulated?

Dr SMITH: That is correct, and the important thing is that if it is an organisation that is providing an evidence-based service with appropriate linkage back to general practitioners and treating specialists, that is to be welcomed as an opportunity to engage in health. But at the moment these are unregulated and stand outside that scope and are not linking back in, to the detriment of our community.

The Hon. PAUL GREEN: And the implications of that are overservicing?

Dr SMITH: Correct, and inappropriate servicing as well.

Dr ANDREW McDONALD: For the record, I am a member of the AMA. I agree; I am very worried about Screen For Life. Who reads these CAT scans? They send out pamphlets to people's letterboxes saying, "Come and get a whole body CAT scan". Who actually reads the scans? Is there any local medical involvement?

Dr SMITH: That is one of our concerns as well. We have approached the organisation to seek clarification on that point. It appears—and it only appears—that most of the CAT or CT scans more technically are actually sent offshore for reporting but again different organisations would have different approaches.

Dr ANDREW McDONALD: Who is responsible for regulating this completely unregulated company?

Dr SMITH: At the moment they fall through the cracks in our system. As I said, we have reasoned repeatedly to the Fair Trading Commission along the lines of false and misleading advertising. We have also engaged with the Health Care Complaints Commission along the lines of inappropriate and again unregulated involvement or targeting of patients again in that false and misleading advertising type point as well. Each of them have said in repeated letters and conversation back that it does not fall in their arena because it is an organisation as opposed to an individual.

Dr ANDREW McDONALD: If I get something in my letterbox I go and pay for a scan. Do you know how much the scans are?

Dr SMITH: Costs run upwards of $800.

Dr ANDREW McDONALD: So $800, none of it is rebatable because they are not truthful.

Dr SMITH: Yes.

Dr ANDREW McDONALD: And I am found not to have cancer and do have cancer and it gets missed—

Dr SMITH: Correct.

Dr ANDREW McDONALD: —there is no comeback to anybody, is that right? They cannot sue them?

Dr SMITH: As far as we understand it. That is difficult but I will hand to my colleague.

Mr TOOK: There is potential for civil action but querying what indemnity that organisation may have to meet that particular claim is unregulated. Whereas the medical profession, as you would be well aware, has a mandatory requirement for indemnity insurance.

Dr ANDREW McDONALD: So there is no record of that scan available to the GP to read, for example? Is anything provided to the patient? Are the scans given to the patient?

Dr SMITH: We do not know, and therein lies some of the origins of our concern.

The Hon. HELEN WESTWOOD: I think you have answered my question. As for the feedback that you have had from both Fair Trading and the HCCC, are they both referring you to the other organisation or are both just saying they do not have the power?

Dr SMITH: Largely it is a game of ping-pong, referring us to the other organisation.

The Hon. HELEN WESTWOOD: Have you had the opportunity to meet with them so that there are the three organisations in the room: the AMA, Fair Trading and the HCCC?

Dr SMITH: At this stage we have not had the opportunity to sit all three of us in the same room.

Mr TOOK: But we do have a liaison committee with the HCCC, and through that committee first things are discussed which indicate—I think they led to moving for own-motion powers. Our submission today relates not only to the own-motion powers but for certainty extending the scope of what those powers mean.

Dr ANDREW McDONALD: Does your amendment on page 5 capture that? Your submission states, "In our view, section 7 ought to be amended …", with the amendment from the AMA, the wording of the clause, "which affects, or is likely to affect …". Would the amendment you propose bring Screen For Life under the Act?

Mr TOOK: We believe so.

Dr ANDREW McDONALD: What is the downside of this? It has not been done, probably on advice rather than a loophole. What would be the problem with this for the opponents of such an amendment?

Dr SMITH: I guess the largest question is it comes down to resources available to the HCCC to pursue or to investigate organisations that would be brought to question. Through investigation, as some of the Committee members are aware, it does not necessarily mean that it is a negative outcome. There may be a reassurance or a positive outcome saying, "No, things are fine". But by that process of being reviewed and in that peer review process you then sort the wheat from the chaff, as it were.

CHAIR: In terms of material that could be misleading, you have talked about the AVN, black salve and body scans. Are there other examples that the AMA is aware of that the community and this Committee should be aware of?

Dr SMITH: Yes. Unfortunately I did leave a new example on my tablet at my desk and I apologise for that. Again, it was approaching through the seniors card reference list, advertising turmeric powder—turmeric as in the herb or spice—and its healing properties through Ayurveda and alternative medicine, which would help with particularly osteoarthritis and joint inflammation. This was mailed directly to people holding seniors cards and the logo of the seniors card was in the top right-hand corner saying they offered a seniors discount.

CHAIR: If any other examples come to your attention could you let the Committee know—if you would take that as a question on notice?

Dr SMITH: Yes. We will take that on notice.

The Hon. HELEN WESTWOOD: Have you taken that up with the organisations that administer the seniors card list?

Dr SMITH: Yes, we have, in regard to the body scans and we have contacted them and written to them directly.

The Hon. HELEN WESTWOOD: What was their response?

Dr SMITH: We have not heard anything back yet, as far as I am aware.

CHAIR: Your submission proposes an increased use of warnings under section 94A of the Health Care Complaints Act. As the statements can only be made at the conclusion of an investigation by the HCCC, should the HCCC be more proactive in making investigations into organisations that promote misinformation? Are you suggesting that you should be able to issue warnings?

Dr SMITH: Correct.

CHAIR: At what point would the HCCC feel comfortable in issuing a warning? Are we talking about the precautionary principle here, where if you think there is any risk at all they issue a warning, or would a

certain amount of evidence need to be gathered before a warning could be issued? Do you have any criteria around which you might make that decision?

Dr SMITH: That would obviously be on a case-by-case basis. If we use black salve as an example, it is clear evidence around the world, and as substantiated by the Therapeutic Goods Authority in Australia, that it is not—for lack of a name for it—kosher. It does not work. It is a lot of baloney, by any stretch of the imagination. Excuse my colloquialism. So something like that already has the evidence available and could be very much put onto a warning register like this and readily accessible to both community and practitioners. If we are using the anti vaccination network—to use its true name as it stands now—as an example, an investigation to look at what material is being disseminated would be a simple process but acknowledging, obviously, it would have to come through as a concern that would then be investigated, and resource questions for the actual investigation would need to be balanced as well.

Mrs ROZA SAGE: In your submission you note that the Commissioner of Fair Trading has been responsible for investigating some matters, as we have already discussed, where it would be preferable that the HCCC be the responsible investigating body. Aside from its relevance to public health, can you elaborate on why you believe it is more appropriate that the HCCC be the responsible investigating body?

Dr SMITH: Firstly, we are relatively agnostic about for whom the remits would fit, other than the fact that the health expertise within the Health Care Complaints Commission would be essential to ensure appropriate investigation.

Mrs ROZA SAGE: Does the AMA have any concerns with the operation of the powers of Fair Trading?

Dr SMITH: Again, we are relatively agnostic about who this power should rest under, with the exception that having that access to the health expertise that exists within the Health Care Complaints Commission would see it fit more readily under the remit of the HCCC as opposed to the Department of Fair Trading. However, I would imagine that direct liaison between those two departments would be essential.

The Hon. HELEN WESTWOOD: Earlier this morning we heard from Fair Trading, which gave us the example of the Food Authority since it has been established. Fair Trading does not take that much action in relation to misleading information about food or consumer affairs matters relating to food. That is now dealt with by the specialised Food Authority. Fair Trading suggested that the HCCC, if it had extended powers, could fulfil a role similar to that. Do you have a view about that?

Dr SMITH: Again, if it rested within the HCCC you have access to those pre-existing knowledge bases and expertise within the health system and certainly we see that would be the preferred place for it to sit.

Mr ANDREW ROHAN: You mentioned—

Dr SMITH: Plus, the HCCC currently has better assessment and regulation processes to action any investigation appropriately.

Mr ANDREW ROHAN: You mentioned that websites promoting alternative health measures, treatments or cures should be answerable for the claims made by the site, including through an appropriate forum for complaints and prosecution established for unrecognised providers making false or misleading claims. What do you think would be an appropriate and sufficient complaints process to deal with that?

Dr SMITH: I guess firstly it would be whether or not the product is backed with appropriate evidence to substantiate their claim. The process would be very variable based on whether you are looking at a product, a person or an organisation. So there would have to be flexibility, partly because obviously when you look at a product there is a lot of intersection with Federal, particularly the Therapeutic Goods Authority and also Federal legislation. If you are looking more specifically at an individual, you then have some potential intersection if they are a regulated health care practitioner via one of the 14 boards in New South Wales or whether they are an unregulated provider. So you would change the investigation process accordingly. But ultimately it should be held to the same standards that medical practitioners and other health professionals are held, which is community expectation, evidence and peer review.

Mr ANDREW ROHAN: What sort of penalties do you think should apply in those examples?

Dr SMITH: Firstly, I would say we are obviously a medical organisation and that goes past our knowledge and expertise. I leave that in the hands of those with the legal expertise about how best to annunciate those kinds of penalties.

Mr ANDREW ROHAN: But the AMA has the legal experts?

Dr SMITH: No. We are a medical professional organisation which represents the community and also our medical professional colleagues, and we are political advocates. But by no means are we legal experts.

CHAIR: Presumably the penalties would need to be sufficient to be a deterrent from putting such information on their website?

Dr SMITH: I think that would be correct, and that is as far as we would be comfortable with.

Dr ANDREW McDONALD: I have a couple of questions, one on cancer and one on stem cells. Lots of people with cancer use unscientific therapy as well as standard treatment. How much evidence of harm does the AMA get of this practice? Is it common or uncommon?

Dr SMITH: I think even if you move past the terms for cancer patients and look at all of medicine, my daytime job, other than being President of the AMA in New South Wales, is as a dermatologist and I treat a lot of patients for eczema and psoriasis. Often these are chronic, relapsing conditions and they are very common in our community. As a result, there are lots of opportunities for patients and parents of patients to intersect with complementary and alternative medicine practices, as well as other things they can find on the internet, looking for cures and hope, which is all understandable and compassionately we all feel for. The difficulty is that capturing the amount of that intersection and how often people seek complementary or alternative medicine and other opportunities is not captured because it sits outside regulation ultimately. So it is hard to collect, but I know that it is a very common practice that people seek opportunity.

Dr ANDREW McDONALD: What about evidence of harm—where a patient is harmed by either the treatment or by neglect in standard treatment?

Dr SMITH: I guess one significant concern around black salve, and why in particular the Therapeutic Goods Authority has made a very strong statement around it, is that people would choose that in preference to actually attending their appropriate medical intervention or follow-up. That is the risk around that broader, unregulated complementary and alternative medicine space where people will no longer attend for follow-up or ongoing care for what is evidence-based medicine. To capture the numbers of that is difficult because it is all happening in an unregulated environment.

Mrs ROZA SAGE: What would you say to your protagonists who say you are impinging on their freedom of speech and choice to use one or the other by talking about conventional medicines as opposed to alternate medicine?

Dr SMITH: My personal experience again as a dermatologist is that often people will seek to do both from a point of view of intersecting with evidence-based westernised medicine and then also looking for other avenues. Usually what happens is that at some point in time it becomes a question of cost and they are not able to pursue both. They then have to choose, and being able to provide information, evidence and support for them to choose whichever one they want is fine. But the question is, if we take it to the previously proposed cancer intersection, if they are being offered opportunity to try, for sake of argument, not that it was being advertised for this, cumin powder, we know there is no evidence for this, then that would be a concern.

CHAIR: The AMA accepts complementary medicine as part of the suite of possibilities available for patients, but the concern is where there is no evidence base to the treatment. Is that a fair summary of where the AMA sits generally to complementary medicine?

Dr SMITH: I guess ultimately it comes down to evidence and providing that things being advertised or offered actually are going to benefit patients as opposed to the potential for harm, based on components within what is being provided. It is a more complex discussion around complementary and alternate medicine as a whole, most definitely. In extreme cases, if it is followed without some intersection or discussion with what we in Australia believe is best practice, which is western evidence-based medicine, it is a concern. We have had

examples even in my working space in dermatology where people have chosen not to intersect and follow complementary and alternate medicine practices, leading to death in a very famous case in New South Wales.

CHAIR: Do Committee members have further questions?

Mr ANDREW ROHAN: May I ask a question outside the scope of reference?

CHAIR: Depends how far outside it is.

Mr ANDREW ROHAN: We discussed conventional and alternate medicine, but there are other cases based entirely on faith medicine. What is your opinion of that, if it exists? Some people are given, say, three months to live but after going to church, praying and that sort of thing their life is extended by 20 years. How can you explain that, in your opinion?

Dr SMITH: That is why I love medicine, because there is grey everywhere in the sense that we have statistics. To use pancreatic cancer, which is a very popular discussion point most recently, on average you have six months to survive after being diagnosed with pancreatic cancer in Australia. We have very good results compared to the rest of the world and it still is only six months. I use that example acknowledging a friend of mine whose father passed away from pancreatic cancer in the last two months; however, he was able to hang around appropriately for 12 to 18 months after his diagnosis. It is moving beyond that concept of we know what the statistics say on average this is what the result or outcome is going to be.

But patients are individuals and they are not necessarily a statistic per se. There are patients who will well and truly beat those stated odds, and there are patients who will not even make those stated odds. When you come down into the faith-healing space, it is very complex because we know that there is an important part of positive approach to your health and engagement from that point of view that it is important, even if it goes to a question of improving quality of life for the time you have.

The Hon. PAUL GREEN: One would view it as being part of the holistic approach anyway: spiritual, natural, physical and psychological. In light of the cannabis debate in the public arena, because we are talking about different research and the impacts of cannabis use, does the AMA have a view?

Dr SMITH: Yes, I can comfortably comment on that. Obviously, I have spoken about this both at the parliamentary inquiry in New South Wales last year on behalf of the New South Wales Australian Medical Association, but also it has been a very popular discussion point and I am the primary person within the Federal AMA that people seek comment on medical marijuana. I guess it is termed "an accidental expert", as it were. But, ultimately, the question around marijuana is complex. I could speak for a very long time on it, but I will not for the sake of the Committee's timings. It comes down to looking at the various conditions available, and they are looking at the treatment option that it could fit. You have very distinct discussions around the terminally ill patient, the chronic-pain patient, the multiple sclerosis patient who has spasticity. I note specifically in that space in Australia we have a synthetic cannabinoid, which is based around cannabidiol as a key component, which is a part of the marijuana plant and not the tetrahydrochloride component.

The Hon. PAUL GREEN: An extract.

Dr SMITH: It is an extract. It actually is available in Australia registered through the Therapeutic Goods Authority [TGA]; it has gone through all those appropriate channels. So there are some elements available and that is in that spasticity space with multiple sclerosis. Obviously, there has been a lot of media attention in that paediatric-epilepsy space. At the moment in America through their Foods and Drugs Authority, which is our Therapeutic Goods Authority equivalent, there is a trial being conducted with their approval in paediatric epilepsy. It was approved at the end of last year and has been going now for about six months. Their plan is to recruit about 100 participants to that and will release the data as available. There are some very early preliminary results out of that trial at a six-month report, but it is too early to comment, obviously, because more information needs to be provided and they had recruited only 25 patients of the 100 they are planning to recruit.

Then if you look towards glaucoma, as an example, the evidence in glaucoma says that in actual fact you have to be smoking a joint every hour for 24 hours to have the same benefit of current best-practice medicine. So, practically, that is probably not really sensible. There is evidence growing in that paediatric-epilepsy space and there is good evidence in that acute palliative care pain space also to control nausea and vomiting as complications about chemotherapy agents. The difficulty is that it is an illegal product, it is illegally

grown and illegally obtained in Australia, with that one exception in multiple sclerosis of that drug that has been approved, which is the synthetic component.

The Hon. PAUL GREEN: This inquiry is into false and misleading information, practices, et cetera, so a lot of that surrounds it.

Dr SMITH: Correct.

The Hon. PAUL GREEN: Would your view be that to go down that path we really should leave it to the TGA to look at the research and come up with the findings?

Dr SMITH: The research is critical. Having the TGA as a centrepiece of any regulation or law within Australia is critical because that is their job. But the research capacity is very important. We have that scope in Australia where things are yet to be fully proven, as is the evolution of medicine. Essentially, in medicine you start with a single case where something goes well or otherwise. Then you find that there are several cases of that and you build that into a case series. That then might go to the next step to go, "Well, we need to investigate this further" to see if there is something real about this that can be documented positive from a short-term and long-term sense but also documenting the negatives from a short-term and long-term sense. Then you go into clinical trials. That is a very regimented approach, but it is a safe approach for both participants and the community as a whole and they receive information about it. The Therapeutic Goods Authority is important in that process. Allowing capacity for research whilst this is happening certainly is important as well because this is a discussion that is happening globally.

Dr ANDREW McDONALD: We have talked about the Australian Vaccination Network and Screen For Life. Are there any other major groups that the AMA is worried about at the moment that would be captured by this legislation you propose?

Dr SMITH: I guess our concern is the ones we are not aware of. Obviously, we are seeing those that bubble up through patients intersecting with our members, who then bring it to our attention, or the community who bring it to our attention, but I am sure there will be others that we are unaware of.

Dr ANDREW McDONALD: That brings me to the next part of the question, which is stem cells, which, as you know, is a growth area. Have you had any approaches from your members about inappropriate stem cell therapy?

Dr SMITH: Not that I am aware of at this stage.

CHAIR: Thank you both for appearing before the Committee today. The Committee may wish to send supplementary questions to you in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any questions if we send them to you?

Dr SMITH: Yes, we would.

CHAIR: Thank you and thank you again for appearing before the Committee today.

Dr SMITH: Thank you very much for having us too.

(The witnesses withdrew)

TIMOTHY VINES, Vice-President, Civil Liberties Australia, before the Committee via teleconference, affirmed and examined:

CHAIR: Thank you for agreeing to appear before the Committee on the Health Care Complaints Commission to give evidence via teleconference today. The Committee appreciates your making yourself available despite your busy schedule. Can you confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

Mr VINES: Yes, I have.

CHAIR: Do you have any questions about that information?

Mr VINES: No, those documents seem fine.

CHAIR: Would you like to make an opening statement before we start the questions?

Mr VINES: I extend my thanks to the Committee for inviting Civil Liberties Australia to take part in the proceedings today. I also extend my thanks to the secretariat staff for making it all possible and for showing a great deal of patience in setting up the teleconference with us. Just a little bit about Civil Liberties Australia [CLA]: It is a not-for-profit organisation and association established under the laws of the Australian Capital Territory and we argue for human rights, those that are held and enjoyed by individuals and groups of individuals.

We keep an eye on laws that are being passed by State and national parliaments and on the actions of government to make sure that they do not unduly trespass on human rights and civil liberties. As an important point, our focus is on human rights and we do not advocate for corporate rights such as the concept of corporate free speech; however, and it may be relevant for the proceedings today, there may be times, especially with small not-for-profits, when it is impossible to distinguish between the speech of an individual and the speech of an association.

I would also like to put on record our position in regard to what is probably the elephant in the room—that is, about vaccinations. Our view as an organisation is that public immunisation programs have time and time again demonstrated their effectiveness at reducing mortality and morbidity from vaccine-preventable diseases such as measles and whooping cough. We are firmly in favour of the science behind that and in favour of programs such as the National Immunisation Program and childhood schedules.

Where we will be proceeding from today is on the basis that limitations on human rights can only be justified if they are narrowly designed and, in particular, they have to have a legitimate aim of dealing with particularly harmful types of speech such as fraud, which we think is a much more serious type of speech than just misleading conduct. We are also firmly of the view that an individual has the right as a competent adult or even a mature young person to make decisions concerning their health regardless of whether a medical professional believes that decision will lead to a beneficial or harmful outcome. I do have more here but it might be best if we proceed to questions, if that is best for the Committee.

CHAIR: The first question goes to the issue of vaccination. The Committee has received evidence that vaccination levels in certain areas of New South Wales are too low to offer proper protection to all residents, which is a fact you recognise as worrisome in your submission. If anti-vaccination organisations are able to continue to promote vaccine refusal, what in your opinion should be done to counter this misinformation and ensure the safety of public health?

Mr VINES: One thing that we would point to is the national agreement that the Commonwealth and the States and Territories have signed around essential vaccination. That agreement sets out the responsibilities of the States and Territories and the Commonwealth in terms of funding and delivering vaccinations. One of the objectives of that agreement as stated in there is to ensure that information is being disseminated to the community on the benefits of vaccination. So we would say that rather than focusing on the activities of outlying fringe groups like the Australian Vaccination Network [AVN], for example, it really is the responsibility of the States, Territories and Commonwealth to make sure that they are living up to that objective. They need to make sure that they are promoting the benefits and are out there in the community—especially

communities that have been identified as ones which may have low vaccination and immunisation levels—selling the message.

I think one issue that is particularly relevant is while it might be tempting to deal with these groups and people who oppose vaccines, I think that there is scope and certainly there is some evidence to suggest that anti-vaccination views might not necessarily attach to all vaccines; they might attach to specific ones. I think that there is scope for health professionals and for the State to at least work on a patient-by-patient and parent-by-parent basis when they come into a health clinic to talk about the range of different vaccines, to acknowledge that they are different from one another and to see if they can address the concerns of parents in that way.

CHAIR: But as an overriding view I think you would take the view that not enough is being done by governments to educate people about the importance of vaccination.

Mr VINES: I think that one of the issues is that vaccines and immunisation programs have been too successful for their own good. I do not mean to say that we should be doing less on that; I just mean to say that we have eradicated endemic measles in Australia, whooping cough is in most areas of Australia a rather rare condition and, of course, we are on the verge globally of eradicating polio. The generation of people who grew up knowing people who died or suffered lifelong disabilities from those illnesses has receded. That is all due to the successful nature of vaccination programs.

But I think that as it has receded people now become more focused on those very rare instances where there is an adverse reaction to a vaccine. We have seen that recently in the 2010 rollout of Fluvax for under-fives in Western Australia. People hone in on those single instances because they have forgotten how terrible these diseases used to be in the community in general. I think that we maybe became too complacent and thought that the evidence spoke for itself and we may have conceded the ground on this issue to people who have come in and played up rare events so that is now all that people are exposed to.

Mrs ROZA SAGE: The Committee has received evidence that vaccine opponent groups such as the AVN—it is not the elephant in the room, it is quite in the room—overthrow debates with extreme claims, thereby removing any opportunity for a legitimate public discussion about improving vaccination programs. What is the most effective way to ensure that any debate in this arena is conducted in a meaningful and constructive manner?

Mr VINES: It is an interesting question. I think there are parallels that can be drawn with some debates in the United States recently on matters like climate change and climate change denial and even with things like evolution versus creationism. Many climatologists or evolutionists now will not engage with these particular groups, finding that the debates are unproductive and, as you say, it is essentially used to swamp the argument.

When it comes to climate change and evolution, I think it is okay if people want to just vacate the field and not engage in those debates. But in this case, because we are talking about an immediate health impact or a future health impact on an individual, I do not think that the health profession or government can say that we do not want to engage with these people because it gives them a platform or we do not want to engage with these people publicly because it lends credence to their arguments. I think that the government has a responsibility and the health profession has a responsibility to try to engage in public forums with these groups.

At the same time, though, doctors and nurses and health practitioners have one great advantage. That is that they maintain a doctor-patient relationship which is private and which is within the walls of their clinic. It is there that the focus should be on making sure that misinformation is corrected. Again, there is literature to suggest that you might have a large percentage of parents who come in concerned about a particular vaccine but once the risks and benefits have been explained and once their questions have been answered in a respectful manner the vast majority of those parents are more than happy to proceed with the vaccination of their child. There is only a small hard core of people who might rule it out entirely, but I think that this is not an area where the health profession or government can just say that we do not want to give these people a platform. It may be necessary sometimes, I guess, to feed the trolls.

Mrs ROZA SAGE: What can be done to protect vulnerable members of the community such as children or people with low health literacy from the dangers of misinformation, particularly that which is proven to be factually wrong?

Mr VINES: Again what I would say is that rather than trying to restrict the speech of other organisations it is about coming into the debate, engaging with the community. I know the Commonwealth Government has recently issued the fifth edition of its guidelines to practitioners entitled "Myths and Realities". It is a guide to doctors on how to address the particular concerns with questions and answers that people might have. Is there mercury in the vaccine? What about the involvement of big pharma and profits and so on?

One of the issues with proposing measures which seek to target the voice of groups like the AVN is that these groups trade on the conspiratorial. They believe that they are the holders of a unique truth that is trying to be silenced. If they can point to moves by the government or by an organised profession to try to shut down that debate or close off their avenues for communicating information then it gives fuel to that particular viewpoint. If there is an issue with people who do not have a high level of health literacy then we might need to look at the way in which we are communicating with them and whether the Commonwealth guidelines in the booklets I mentioned are targeted at the right group or the right level.

Mr ANDREW ROHAN: As you know, the Health Care Complaints Commission attempted to compel the Australian Vaccination Network [AVN] to place a notice on its website advising that its purpose is to provide information about vaccination and that the information provided should not be read as medical advice. The ability of the Commission to make such an order was subsequently deemed ultra vires by the Supreme Court. In your opinion, leaving the legal advice to one side at the moment, do you believe it was appropriate for the Commission to make such orders in respect of the AVN?

Mr VINES: From a human rights perspective, the compelling of speech is just as unacceptable as the banning of speech. While I have great sympathy with what the Health Care Complaints Commission was doing and I accept that it was trying to fulfil its legislative mission to protect the health and safety of the public, as an organisation we cannot support a government that would seek to compel particular speech of individuals or to send a message with which it did not agree. I draw a parallel with things like corrective notices or advertising that the Health Care Complaints Commission can require of company. The distinction is that we do not focus on the rights of corporate free speech or on corporations' legal obligation to maximise shareholder profit. If they seek to do that through fraud or misleading or deceptive conduct then the Government is entitled to correct it because that is an abuse of the market. When it comes to an individual, and in this case the relationship between the management and the AVN itself, which is so close that it is hard to distinguish between the two, the compelling speech is probably beyond what we would consider to be a reasonable limit.

From a different perspective, would the Health Care Complaints Commission consider it appropriate to require an elder in the Kingdom Hall to open a sermon on blood transfusion with a disclaimer that, while transfusion is typically safe and failure to accept a transfusion may constitute unsafe rejection of medical treatment but the congregation is still obliged to follow the church's views? Or would the Commission seek to add a preface to the encyclical on human life and to say that despite the content of that book condoms remain a highly effective method of preventing the spread of HIV/AIDS? The AVN is an easy target because it is outrageous. However, once we give an organisation the power to compel the speech of others, individuals or groups, it becomes very hard to draw a line between which we will compel and which we are happy to continue to spread their message.

The Hon. HELEN WESTWOOD: I want to clarify or to tease out something you have said. I heard your argument that the compelling of speech is just as bad as the banning of speech. You talked about organisations versus individuals. Fair Trading was able to take action against AVN because it is an organisation. I suggest that the fact that it is an organisation gives it some authority. If it were simply an individual making these claims, I suggest that parents and health consumers would be less likely to accept them. Do you not see a difference?

Mr VINES: There certainly can be. I will deal with the AVN in particular and its spokeswoman. When she gives talks at concerts and when she speaks at educational institutions she really is the representative of that organisation. The information submitted to this Committee by groups like Stop the Australian (Anti)Vaccination Network indicates that she is well and truly the controlling mind and voice of that organisation. The Committee's terms of reference deal with individuals and corporations, but they also deal with creating a general community distrust or anxiety. One does not need to be a company to do that. Some people will have an organisation stand behind them to lend them some authority. However, in this case the organisation and the individual are not so far removed from one another.

From a jurisprudence perspective, there was a recent Supreme Court in the United States dealing with the First Amendment and compelled speech. It dealt with a not-for-profit group that delivered an aid program overseas. The Supreme Court held that the group still had the right to free speech and that the Government could not compel its speech. If any distinction needs to be drawn, it comes down to the fact that it was a privately traded company that was pursuing a profit motive and operating in a market in which it was legitimate for the Government to correct abuses. However, when a group is not operating in such a market but, rather, a market of ideas, the Government cannot silence a particular voice. It must come in with its own weight and evidence as an equal participant in that market.

The Hon. HELEN WESTWOOD: If the AVN, for example, required payment for information, whether by way of subscription or some other form of payment, would it then be appropriate for the Government to compel it or any agency to provide or publish warnings on its website?

Mr VINES: One of the points I made in the article that we attached to our submission was that I do not suggest, and I do not think that Civil Liberties Australia would suggest, that private action under the Australian Consumer Law or under negligence would necessarily be an inappropriate interference in free speech. In that instance, the court would weigh up and consider the public interest in protecting that speech when it was, for instance, establishing liability or awarding damages.

If the group were providing a subscription-based service and engaging in trade and commerce—which AVN has in the past by selling books and for which it was held to be engaging in misleading and deceptive conduct—then, as I said, Civil Liberties Australia is not focused on corporate free speech. As a company or as a trading association, if it is encouraging sales by promoting a misleading perspective and that can be demonstrated, it would not be an issue for us if someone sought to take it to task. The issue is whether the Government should take action or should it be initiated by an individual, whether it be a client or a purchaser.

The Hon. HELEN WESTWOOD: As you know, in this case it was initiated by a complaint.

Dr ANDREW McDONALD: The *Australian Health and Medical Law Reporter* article that you included with your submission is brilliant; in fact, it is as good an article on the issue as I have read. The Australian Medical Association has recommended that section 7 of the Health Care Complaints Act be amended. At the moment it is allowed to deal with own-motion complaints affecting the clinical management of an individual complaint. It is that provision that allowed it to prosecute the AVN. The association feels it should be expanded to include clinical management and care of the public or any member of the public. That would mean that groups that put flyers in letterboxes about whole-body CT scans as a screening test would then be able to be investigated. At the moment they are not because they are outside the Act. Does Civil Liberties Australia have any view? You can take that question on notice.

Mr VINES: I can begin with Civil Liberties Australia's likely response on the basis that it has come across similar proposals in the past, but not always in the health context. There is always the risk with this type of reform that we will end up with scope creep or mission creep of the organisation. The Health Care Complaints Commission's submission referred to the percentage of complaints that relate to the type of individuals or organisations on which this Committee is focused. It constitutes only a small percentage, whether it was 2.9 per cent or 4 per cent. Our response would be to question whether this is the best use of resources by the Commission. Is it something that could be dealt with instead by professional bodies that might regulate these practitioners? One issue is that the term "safety" is pretty broad. Not wishing to be too flippant, but we would not want to see the Health Care Complaints Commission being given unlimited scope in relation to that term—for example, like the Robespierre Committee of Public Safety. People still have a right to make clinical decisions about their treatment and what option they will accept or reject.

In the case of companies that are offering full body scans as a diagnostic tool, again, because they are engaging in this activity it may be appropriate for the Government to look at whether steps should be taken to alert people to the risks of such a procedure if they are not provided. At the same time, it is probably something that should not be handled by a body like the Health Care Complaints Commission. It should be handled by a national body, through a government education campaign, or even dealt with in accordance with the existing framework we have for misleading or deceptive conduct in trade or negligence for a failure to warn of the risks involved in a procedure.

CHAIR: Your submission highlighted certain medical practices that are guided by religious beliefs that should be allowed to be promoted. An example would be Jehovah's Witnesses objection to blood transfusions.

That would be in line with individual freedom of speech. Does Civil Liberties Australia believe that a religious organisation should be able to promote procedures that may be considered medically unsafe despite scientific consensus to the contrary? I refer again to the Jehovah's Witnesses example you cited in your submission.

Mr VINES: The short answer is that we would say yes, they should be able to promote those views. Barring very rare circumstances, individuals who are followers of that faith should be entitled to rely upon that advice. One of the issues that has come right to the heart of what this Committee is aiming to do—and it is an admirable task—but there are many things that cannot be established by a randomised clinical trial. Many things that we take for granted as truth and knowledge in this world—things like evolution and climate change, for example—rely on indirect evidence or models. There are also, of course, ways of establishing a personal truth through experience or deductive reasoning.

I do not know if you were watching SBS the other night but there was a documentary on the placebo effect. There are, I suppose, many ways in which people can find a particular truth. For a member of a spiritual group—in the case of a Jehovah's Witness, for example—the fact that if they took a blood transfusion they could be expelled from that movement and denied salvation, according to their belief, is probably going to be a much stronger motivation than the fact that there is scientific evidence that shows that a blood transfusion is physically safe. We have seen similar tensions arise over, say, the protection given to the confessional. It puts these individuals in a very difficult position where you ask them to compromise what they see to be an essential protection for their immortal soul versus a temporary relief of corporal suffering.

CHAIR: Can we conclude from that that you think there should be a distinction made between a religious group and a non-religious group in relation to whether a complaint should be investigated?

Mr VINES: On the contrary. I think that in a secular society with the rule of law and equality of law that if there is a rule such as that that protects a particular form of speech for religious groups there should be an equivalent protection for the speech of people engaged in secular activities. I guess the limit on that would be when we are talking about children who are unable to make their own decisions. In that case, Civil Liberties Australia believes—as the International Covenant on the Rights of the Child says—that the correct test is to consider what is in the best interests of the child. More often than not, that will be the united views of the parents or of the parent but, in some cases, it might be that the State's interest in protecting the child from imminent peril or abuse warrants the overriding of those particular views, whether they are religious or secular.

CHAIR: Thank you for clarifying that.

Mrs ROZA SAGE: Following on and going back to the Australian Vaccination-skeptics Network, or AVN as well, one of the concerns of the Committee is that groups such as the AVN are able to succeed not by winning the debate against vaccinations but by keeping the debate on vaccine safety alive when it has been settled within the scientific community, as you have already said. In your view, how do public health advocates balance between ensuring that a message such as the one the AVN has does not impact on public safety while protecting the freedom of speech of those who dissent?

Mr VINES: I go back to the point that doctors and health professionals, when a patient comes to visit them, have a captive audience. That is the primary opportunity in which to address individual concerns. There are other things that can be done and there are possibly a number of policy options that could be explored, either by a State or Territory government or nationally. There have been proposals in the past to establish a no-fault compensation scheme, for example, for adverse events following immunisation to minimise the community objection to vaccination and to ensure that there is some form of justice to an injured party. Because the rate of adverse events in vaccinations is so low and they are generally transient and mild, the cost of such a scheme would be fairly low.

However, to have it in place and perhaps also linking it to things like the National Disability Insurance Scheme would go some way to addressing concerns that parents might have that if something did go wrong they would be all on their own. I think that is probably the fear that drives a lot of parents to refuse to have their children vaccinated. That is obviously a longer term issue. But in terms of argument, I think as well that there just needs to be a recognition that low immunisation rates in some parts of the community are because of the work of groups like the AVN but are also caused by structural issues: parents who cannot make it on time to appointments because they are working two jobs or because they are sole parents; it may be too far to go to a clinic; or it might be that remote immunisation services are unlikely to make a visit for the next two years or so. I think, in order to maintain good herd immunity, the Government should first look at making sure that

structural barriers to immunisation are addressed. Only then really would it come to having a look at what could be done about countering the arguments of the AVN outside the doctor-patient relationship in the clinic.

Mrs ROZA SAGE: Immunisation was just one example but there is a lot of other information out there. People do not necessarily go to talk to their doctors; they will go onto Dr Google and find out information. So again the question is: How do you think we should be balancing that? Should we be filtering those messages that are incorrect? What is the balance between that and protecting the freedom of speech of those who do dissent?

Mr VINES: Freedom of speech does not mean that you have the right to be the only voice heard or to be the first search result on Google which, in reality, is probably the same thing nowadays. There are a number of measures that governments or health professions can take. It is probably better that the message comes from non-government sources such as general practitioners, members of the royal college or nurses who might have a different relationship with people in the community. Those groups could either use their own funds—or perhaps there could be some assistance offered—to make sure that their websites are optimised in such a way that they are likely to be coming up in the first three hits on Google. Unfortunately, when most people type "Australia" and "vaccination" into Google, the first organisation that comes up is the AVN. I think that part of the battle is not so much silencing that particular website but lowering its priority and listing on Google and to have alternative voices that are spreading scientifically backed information.

CHAIR: Are there any more questions? There being no further questions, I thank you for your appearance today before the Committee. The Committee may wish to send some supplementary questions in writing, the replies to which will form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions that come to mind?

Mr VINES: Yes, that would be fine.

CHAIR: Thank you and thank you for appearing before our Committee by teleconference today. It is much appreciated.

Mr VINES: Thank you very much.

(The witness withdrew)

(The Committee adjourned at 12.53 p.m.)