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 Wednesday 3 September 2014

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The Committee met at 10.15 a.m.

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PRESENT

Mr D. Page (Chair)

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

Legislative Assembly
Mrs R. Sage (Deputy Chair)
Dr A. McDonald

CHAIR: Good morning everyone. Thank you for attending this public hearing of the Committee on the Health Care Complaints Commission. The Committee is holding hearings this morning in relation to its inquiry into the promotion of false and misleading health-related information and practices. Today we will be hearing from Friends of Science in Medicine, Complementary Medicine Australia and the Health Care Complaints Commission itself.

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 the coverage of proceedings are available at the table at the entrance to this room. I now declare the hearing open. I welcome Professor John Dwyer, President of Friends of Science in Medicine.

JOHN MICHAEL DWYER, Professor, Friends of Science in Medicine, sworn and examined:

CHAIR: I 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?

Professor DWYER: I have, yes.

CHAIR: Do you have any questions about the information?

Professor DWYER: No, thank you.

CHAIR: Before we start questions would you like to make an opening statement?

Professor DWYER: I would. I would appreciate the opportunity to set the scene, so to speak. First of all, thank you for holding the inquiry; I think it is very timely. The problem that we are dealing with is a pervasive one. It is somewhat frustrating in that in this most scientific of all ages so many consumers, so many people in the public have little or poor knowledge of the health literacy standard; they do not really understand, for example, the importance of taking a personal interest in the evidence for any treatment that is given to them by a doctor or anybody. The penetration of pseudoscience and misleading information into the community is very pervasive and the regulatory environment for protecting consumers is, I feel, very weak.

I thought I would just mention that in an organisation like mine we have been campaigning to strengthen the role of the Therapeutic Goods Administration [TGA] in terms of protecting consumers. There have been numerous recommendations made to give the TGA more power to do this because we have been able to document numerous occasions where it has failed consumers. You only have to look at all of the failure to control the false weight-loss claims that have been put out. We know that the recommendations that have been made are lying on the Minister's desk in Canberra and the information we have is that the Government is extremely unlikely to make any changes. Mr Dutton has said in Parliament that he thinks the TGA is fine and does not need to have any more powers. We think nothing could be further from the truth. So consumers are not getting the protection they need from therapeutic goods and practices from the TGA.

I also wanted to emphasise, because it will have a big effect, I think, on the future role of the Health Care Complaints Commission [HCCC], that following numerous interactions now with the Australian Health Practitioner Regulation Agency [AHPRA] in the first few years of its new life with more registered practitioners, chiropractors, osteopaths and traditional Chinese medicine and problems that have been associated with registered health practitioners going way beyond the acceptable scope of practice for their profession, when we have approached AHPRA with documented problems—registered chiropractors claiming that you should bring your child with autism to them for treatment and the like—it has been made perfectly clear to us that, under the current legal structure, AHPRA has no power to influence the scope of practice of a registered medical practitioner. The standard codes of practice about being good people and being ethical, et cetera, there is no nitty-gritty detail about what services these practitioners can offer or what they cannot offer.

When we even went to the AHPRA and then the Physiotherapy Board because we had documented at Friends of Science in Medicine, much to our distress, some 80 or so physiotherapists who were not offering standard physiotherapy but were offering sarco-cranial therapies and pseudoscientific practices, we were told to take them to the HCCC, "They are the only agency that can handle this." We are very conscious of the fact that we have swamped the HCCC with complaints about these sorts of things. In the submission that we have put

before you we have documented numerous examples of registered chiropractors, osteopaths, doctors and nurses who have strayed, in our opinion, and are offering misleading information and misleading practices to the public, as well as, of course, a lot of information about unregistered medical practitioners who are offering a whole range of pseudoscientific services that we think require addressing.

If you look at the HCCC itself, and we all welcome the fact that the legislation that you passed gave the HCCC some more powers in terms of being proactive, but if I could tell you a very quick story that you have probably heard before, but put it in the context of today's hearing. If you have not heard this story, I want you to imagine that a handful of doctors and even some dentists refer patients to a New Age healing clinic—patients with quite serious medical conditions—and when they get to the clinic they meet the leader of this clinic who tells them that he used to be, in his original life, a tennis coach, but he had a vision and knew then that he had to set up an esoteric healing clinic to help patients. He tells his patients that he is the reincarnation of Leonardo da Vinci and patients are subjected to a whole series of nonsense therapeutic approaches—esoteric breast massage; they claim they can massage your back and actually massage your lungs if you have lung conditions; the practitioners say they have the power to talk to a woman's ovaries and learn about that; and they explain that all illnesses are due to past misdeeds in previous incarnations of your life.

On the website the leader of this group says that he knows more about medicine and healing than anyone in the history of the world has known about it and that, indeed, he knows about a technique called chakra-puncture, which is a form of acupuncture that predates any of the Chinese involvement in acupuncture, and he can use it to treat people who have had chemotherapy and their body needs to be purified of these things. Patients go to this unit and they are shocked at what they hear so they go to the Health Care Complaints Commission and they say this is what happened. To add to it, they say, "One of the reasons we accepted that there might be something in this is that we were referred by our doctors, including some specialists." The complainant says, "Surely, the doctors should be questioned as to why they would refer us to such a service?"

So the HCCC gets the complaints, it says, "We will have to consult the medical board about the doctors and we will look at your complaints" and it comes back to the complainant saying, "The medical board says the doctors were just expressing an opinion when they sent you to these people. They were not really endorsing this service", despite the fact that the code of practice for doctors makes it perfectly clear that you can only refer someone in good conscience if you know the clinical competence of the people you are referring to and that that clinical competence would be accepted by the vast majority of your peers. But the HCCC's report back said, "This is just doctors expressing an opinion", and since no actual physical harm was documented to these patients, despite the fact that there was psychological harm and despite the fact that one patient claimed that she had spent $30,000 with them—as if robbery is not harm—and the HCCC, since January 2013 at least when these complaints have come in, have not done anything about this organisation.

To me, it is a classic example of the fact that the HCCC is crippled by a lack of capacity to act. You would have thought that a prohibition order would have gone out immediately saying, "Cease and desist. You cannot continue to do this to the public. If you continue to do that we will prosecute you". But no. We are going to suggest today from Friends of Science in Medicine that the HCCC may not have the resources that it needs and it does not have the adequate powers, and we have made recommendations to you for five or six changes that we think would be crucial. We are recommending that there needs to be much more proactive action to stop the spread of misinformation and to stop practices that cause harm, but the definition should be broadened to make it perfectly clear that people who can almost be indoctrinated into a cult or can have psychological damage, be robbed or have a condition not properly diagnosed and treated in a timely manner because they have been mislead, should be addressed.

To give you examples of misleading pseudoscientific dangerous misinformation and practices given to the public, we have given you examples of websites related to homeopathy, dousing and intuitive readings, people who charge people to use crystals to turn a breach baby, kinesiology, light therapy, the naturopaths who use pseudopathology tests, live blood analysis—which the Royal College of Pathologists has studied and shown to be absolute nonsense—and we have included some chiropractic and osteopathic anomalies, which we think are very serious, and also some doctors and nurses who are letting the side down.

In summary, this is a pervasive problem. The hearing is timely. Within our realm here in New South Wales we are lucky to have a Health Care Complaints Commission—not every State has one, as you know. But is it a toothless tiger? Not completely, but certainly it needs to be proactive. One of the major points we want to make is that by being a commission that responds to complaints it is always responding after the event. The whole problem in terms of consumer protection, as we see it, is in trying to do things to make sure that you do

not have to have a complaint because you have stopped the offence from happening in the first place. Thank you very much.

CHAIR: I might kick off questions by referring to your statement. To a layman, having doctors and specialists fully trained making referrals along the lines that you were talking about would give most people considerable concern. You indicated that you thought that part of the problem might be that the HCCC only forms the view that they are giving an opinion. The first question is: Are these people who are trained referring patients to people who are not trained, doing it, do you think, in part because they know what the law is? Or are they doing it because they think that the treatment that is potentially available might be helpful?

Professor DWYER: It is hard to know what the motivation is. There have been numerous reports that the organisation we are talking about, Universal Medicine based in Lismore, that some of the doctors have a financial interest in Universal Medicine, and if that is the case that adds to the problem. That has been investigated and those claims have been made many times. I am not sure whether they are true or false.

CHAIR: Would that be an ethical issue for the medical profession?

Professor DWYER: If that is the case that is a totally unacceptable practice on the part of medical practitioners. There is no doubt whatsoever in my mind that 99.9 per cent of doctors would be horrified to think that these people would place patients in the hands of these people. One of the doctors who was investigated and did not even get a disciplinary warning is a cardiothoracic specialist who sends patients with severe respiratory problems for lung massage from these people. Could it be that these doctors actually believe? I cannot say, but certainly when five or six doctors who are involved in this are brought to the attention of the medical board through the HCCC, it is quite appropriate for the HCCC to ask the medical board's opinion about this. A response comes back that the doctors are just exercising their right to state an opinion about a therapy. The average layperson would be horrified to think that that is the case, but there is much more responsibility for a doctor. If I refer a patient of mine to someone, I have a big responsibility because naturally that patient trusts me to think that I am acting in their best interests and that this person is competent to do what I have referred the patient to do.

CHAIR: Are you suggesting that the HCCC legislation should be amended to tighten that up?

Professor DWYER: Absolutely. In our country we are not going to get away from the fact that the responsibility for the problems we are talking about in this hearing will be divided, but the solutions to the problem will be handled by lots of different agencies in our country. If you look at consumer protection in the health arena you have the ACCC, Fair Trading, the HCCC—there is a similar organisation only in one other State. There is a review of AHPRA that is to be finished by the end of the year and virtually everybody whom I speak to says that the way the Government has set up AHPRA is such that it is totally inadequate in terms of its ability to protect the public.

The whole idea of having more registered health professionals was that the boards would then make sure that the standards of operation of those professionals who are registered would be first rate and protect the public. Yet we have had to fight with some of these boards, like the Chiropractic Board of Australia, to get them to issue a statement to their members saying they were not to oppose vaccination of children. When we went to AHPRA they said, "We cannot respond to any of your complaints about the chiropractors who were embracing subluxation theory and telling parents they can treat asthma, colic, autism and attention deficit". That extension of their scope of practice is way beyond what the evidence base suggests, but we cannot do anything about it. When the review is on, "Please, Professor Dwyer, will you get your organisation to write to say we need to have this all changed?"

In fact, if you look at the terms of reference of the HCCC in New South Wales, if it was actually able to do what its charter says it should be doing, we would be much further advanced. If you have time I can go through the six major recommendations that we have made, but without more powers and without being able to respond to the sorts of things—I am sure you will hear from many people. After much thought, we feel that the Health Care Complaints Commission should become a health care consumer protection commission. The Parliament decreed that this agency, which traditionally has only ever responded to disasters, people come in after the event—should be able to be proactive. But what does that mean? When you look at the resources available on the website, it looks as though there are only two people who are involved in the investigative side of it. Do they have the resources to do things?

We had no trouble pulling up websites demonstrating numerous examples of potentially damaging practices offered to consumers that we have documented for you here. If the Health Care Complaints Commission became a consumer protection commission and used that proactive power in the way we have outlined here, with an emphasis on provision of deterrents to the propagation of misleading and false information in the first place, it would be a much more useful organisation. But it needs resources to do that. The organisation at the moment has hardly any resources. We have no trouble being proactive and being able to supply you with examples.

CHAIR: In your submission you recommend that "businesses, organisations, and commercial providers that offer information to the public about health and health care should be regulated according to an enforceable code of conduct". For non-registered professions, how do you envisage that this may take place?

Professor DWYER: We have a code of practice for unregistered practitioners. The code requires that there be a solid evidence base associated with what is being offered to the public. The issue is the enforcement of that code. Even when the ACCC gets involved with someone, if you prosecute somebody for a misleading or dangerous practice, the judgement and the information is only about that one person; whereas we need to have some things that act as a deterrent. If you had people offering misinformation to people and that was obviously breaking the code of practice that has been set for unregistered practitioners and it became known that a number of these people were in fact disciplined and/or fined for that practice, it would make people be more careful about what they say.

If you look at the websites you will find hundreds of unregistered practitioners making the most outrageous claims for what they can do, including for serious things like cancer. One element of the code of practice for unregistered practitioners is that they are not allowed to say that they can treat serious illnesses like cancer. Yet that is a problem we have. So I think the unregistered practitioners, many of whom might be giving perfectly sound common-sense advice to people, need to know that if they are propagating misinformation and making false claims there will be some consequences. This is where the proactive nature of the HCCC comes in, not waiting for complaints but having the resources to do what we are doing, which is looking at websites and what is being said and advertisements on television and listening to the radio, having an eye on the media and how this stuff is being propagated and enforcing that.

We believe that once a few of those prosecutions occurred or warnings and disciplines had been made public and people have been forced to change the information on their website, people might be more careful in what they say and the public would be protected in that way. We think that is important. The same thing applies to our second recommendation when we are talking about people who offer therapies that are inappropriate. We have documented numerous examples of that. But if you look at the HCCC at the moment in terms of what it can do, it says that we can issue a prohibition order and then it goes on remarkably to say that if they ignore the prohibition order the practitioner must tell the client that they are ignoring the prohibition order. What possible sense does that make?

CHAIR: You are suggesting that a beefed up HCCC would be the right body to enforce the code. Is that what you are saying? I think that is what I am hearing.

Professor DWYER: I think in terms—

CHAIR: If so, what kind of penalties would you envisage should be applied? I suppose it depends on the nature of the breach, but have you given any thought to that side of it?

Professor DWYER: There is an approach that we have taken at the Department of Health in committees that I have chaired, looking at risk stratification and the punishment should fit the crime. There could be a perfectly reasonably warning, "You have to stop saying this and document to us that you have stopped saying this and there is a timetable on it." A range of penalties could be generated and I think that would require some work on the part of the Commission to look at that, but they could look at other examples of the way that works. It should not just be the HCCC. Much of the work that the HCCC is doing or needs to do, in our opinion, would be unnecessary if the TGA were able to do its job properly.

For example, we complain about misinformation to the public, which is so common, that suggests that every Australian should be taking a vitamin supplement every day, that if you start the day without looking after your inner health and taking some good bacteria you will not have a good day. Australians are wasting millions of dollars a year on supplements and being misled into thinking that health can be taken out of a bottle rather

than changing your lifestyle. All the misinformation that Swisse, Blackmores and others propagate on our television—they are making therapeutic claims, executive stress formulations of vitamins will give you energy, this will relieve your stress—where is the TGA? Is that not a therapeutic claim? The TGA says that is a food, though, so let us get the Food Authority do it. Then they say, "Hang on a second", back and forward, back and forward, so back to the HCCC.

It should not have anything to do with the HCCC. This is a national problem. The TGA should be able to do it, but year in and year out parliamentary secretaries for Health who are responsible for the TGA have told me—I have a lot of grey hairs; I have been doing this for a long time—that for at least 25 years that it is in the too-hard basket politically. But if we look at the issue that you are looking at, misleading information and the like, telling Australians that—there is absolutely no evidence base—everybody should be taking supplements every day and we are spending an estimated $2 billion to $3 billion on it, it is sending the totally wrong message about prevention and good health.

Mrs ROZA SAGE: In your submission you suggest also that groups that offer health-related information or advice "should be required to openly disclose the nature and purpose of the group, their source of information and any health-specific qualifications". How do you envisage that might take place?

Professor DWYER: We live in the age where many, if not the majority, of the people offering healthcare services do so through some form of social media, the internet and the like. So they are advertising their care. Take a chiropractor, for example, who is saying we should be heavily involved in paediatrics, "We're running a clinic for children. Bring your baby to us as soon as it's been born because the shape of its head may have been damaged in the birth canal and we will adjust it for you." This claim is made or, "If we do this we might prevent autism." If you are going to make a claim like that you should have to demonstrate that that claim is being made based on some evidence base that was credible that would give the consumer some reason to think that this might be a legitimate thing.

If it is just made as a bald claim and there is no need for the person making the claim to back that up with the evidence base we will continue to have these outrageous claims being made by many people and consumers being hoodwinked into thinking this is a therapy they should avail themselves of. I think, again, we would need to work around the codes of conduct for registered and unregistered practitioners to build into that the fact that part of the code should be that for the claims they make there should be a source of information as to where people can read more about this particular mode of therapy and, also, more about the professionalism and the training that has been received by the practitioner. It is those sorts of measures that we want to see. We just do not want to see the influence that comes from a website misleading people. It is a problem for people, this whole health literacy issue.

Just before I came here this morning, because we have notified you of complaints about people offering kinesiology as a totally ridiculous pseudoscience, I googled kinesiology and the first 30 Google entrants are fantastic reviews of how marvellous it is that people can test your muscles to see whether they are strong or weak and they can tell you what other diseases you have and how we should treat you. The first 30 entries in Google before you get to Wikipedia or something are all pro-kinesiology and what it can do for you. This is a difficult era in terms of doing something about this but, again, I think if we do not hold the practitioners, registered or unregistered, to a higher standard than we are doing at the moment and have some teeth to make sure we do hold them to a higher standard, these non-evidence based practices and rip-offs of people are going to continue.

Mrs ROZA SAGE: Who do you think would be the appropriate authority to police these requirements, the HCCC or AHPRA?

Professor DWYER: In terms of advertising for alternative and complementary things, the TGA has responsibility in that it has a subcommittee set up that works independently of TGA but reports to them and is supposed to look at all advertisements, for example, for therapeutic claims. That again is an organisation and a methodology that has failed time after time and you see literally hundreds of reports back to that organisation saying, "Why did you let this weight loss product be advertised", you know, "Eat all you want forever but take this and you'll lose 10 kilograms in three weeks"—nonsense things. The TGA has a role to play here but, again, the thing is not working properly. One of the reasons for our recommendation 5 that an interagency liaison committee be set up is the fact that the responsibilities for the things we are talking about today are so splintered in Australia and the resources are very poor.

When I go to court to testify for ACCC they tell me, "We've had to pick this case very carefully. There are 25 we want to do but we've only got the resources to do this one. It's costly to go to court," blah, blah, blah." It is the same with Fair Trading. I think that while so much of health care in Australia is splintered in a way which we could talk about all day, which is so harmful to our ability to offer cost-effective best care—I am conscious of saying the Health Care Complaints Commission has to do all this when, first, it is a State organisation—we want to have a national program and an interagency committee. I think if there was better intercommunication between ACCC, Fair Trading and the Health Care Complaints Commission using their different experiences to perhaps answer the question of how would you stratify risk and the penalties you might impose and what sort of penalties really would work, that would be a positive step forward.

The resources that the Health Care Complaints Commission would need to do all things we wanted to do would require, I am sure, a much larger expenditure from the State to make that possible. I think the Government should be looking at more resources for it but, again, I deal with all of these agencies. I have just been working with Fair Trading and Queensland police looking at rip-offs in duty free stores where Chinese and Asian people come to Australia and are sold for $1,000 an extract of red kangaroos—the most virile animal on earth and this is going to do all wonderful things for your health. Just looking at the HCCC and the police it strikes me that an interagency group would make perfect sense.

Mrs ROZA SAGE: We have heard that the HCCC and Fair Trading are all working together here. Do you think that there is not enough collaboration?

Professor DWYER: I do not think there is enough collaboration. When Craig Knowles was health Minister many, many years ago he set up a committee to look at this, which I chaired. The result of that was that we recommended there be an interagency committee and maybe three or four times over the last three or four years small groups got together, but it is very informal and the like. I think a formal interaction of the various agencies responsible for protecting the consumer from misleading information and practices might rationalise and make it much more possible to get better use out of the limited resources each of the agencies has because they have huge overlap here.

Dr ANDREW McDONALD: The AMA wants section 7 of the Health Care Complaints Act to be amended. This is to attack people who do screening—they put something in the letterbox for a whole body CT scan. At the moment these people fall outside the Act because it is not a member of the public who gets affected. It has potential for damage. What do you think of that?

Professor DWYER: Absolutely. It hurts, obviously, when you are talking about your own profession, but there are doctors involved in health scams, there is no question about that. We have documented a few of them. If you take the whole body scan situation that is something where people can spend a lot of money and get information that falsely reassures them. There is no scientific evidence to suggest that this is a proper screening mechanism. Again, it is very heavily advertised. You will see, "Come in and we'll basically X-ray everything except your soul, and maybe we can even do that for you." I often hear stories of corporations who have executive physicals say, "Well, we want to have body scans. Do you do that? Do you do whole body scans for our executives?"

There has to be a mechanism to protect the public of putting the brakes on this sort of thing. Now who should be responsible for that? Certainly if it was brought to the attention of the HCCC, which does have responsibility for both registered and unregistered practitioners, it would have to have a look at it. But I am not sure if that is really where it should come from. It should probably come from the TGA. But in terms of the TGA's role with instrumentation things, that is not on its major list of priorities that it does. Again, that needs to be looked at. The point is, I agree with the AMA entirely that that is a situation where if we could strengthen section 7 so that the HCCC could respond to complaints about that, it would be terrific.

Dr ANDREW McDONALD: Would you agree that about 10 per cent of all patients in hospital have some form of adverse event and that about 1 per cent is serious? Would you agree with those ballpark figures?

Professor DWYER: Yes.

Dr ANDREW McDONALD: That is for standard medicine. For complementary medicine surely you can always bring out cases where things have gone dreadfully wrong. Is it greater or less than for conventional medicine? We lose more people from conventional medicine than we do on the roads.

Professor DWYER: I am sorry, Andrew?

Dr ANDREW McDONALD: Is the risk of harm to the public from this non-scientific medicine greater or less than the risk to the public of general medicine where 10 per cent of patients have something go wrong and 1 per cent seriously wrong?

Professor DWYER: I think it depends on what you mean by harm. Most complementary medicines are not in themselves going to do any physical harm whatsoever. There are some exceptions to that. A number of things that traditional Chinese medicine people use can be quite toxic, but if you look at the risk-benefit ratio to a patient, where there is no chance of benefit, your threshold for risk for saying it is not worth taking the risk becomes very low. Of course, orthodox medicine has a high rate of administrating things for people that have side effects and can cause harm. But the risk-benefit ratio there usually is and should be—and most of the time we are very conscious of this as doctors—and there should be the possibility of great benefit if you are putting people at risk. I suppose chemotherapy and cancers are quite significant examples. Many people are going to suffer significantly because they take the chemotherapy, but the potential cure of a cancer puts that risk-benefit ratio in quite a different light.

I think about the whole concept of harm from something which is given under a false premise but which does not actually cause physical harm. The ABC's *Australian Story* program did a story about poor Mrs Dingle, who had cancer. She refused to get medical treatment and instead was treated by a homeopath. The homeopathic preparation did not do any harm; it was totally harmless. However, she was persistently given misinformation and was told to keep away from all the medical doctors and to use a homeopathic preparation. That did her a lot of harm; in fact, it killed her because she never got any effective treatment. We have to accept the fact that homeopathic preparations are just water and in themselves they are harmless. Mr Golden in Victoria is selling homeopathic vaccines for your child. The vaccine does no harm, but the misinformation does an enormous amount of harm.

CHAIR: We heard yesterday from the Australian Medical Association that typically people will seek conventional medicine and complementary medicine, often simultaneously. Sometimes there is an issue of cost. I note in your submission that you talk about the role of the media in that context. If people are looking for more information of a complementary nature, there is a greater tendency to want to self-diagnose. Can you give the Committee some examples of where the media has recommended things that are medically incorrect? I note a *Catalyst* program called "The Heart of the Matter". Are there any other programs you can think of? You also recommend a media liaison program. Can you give the Committee an insight into how that might work?

Professor DWYER: The irony is that much of the misinformation is spread through the media—television, radio and the like. Australia has no code of conduct or practice that says that the media needs to check the information it is disseminating. Perhaps that is an impossible ask. What is really objectionable is the role of the media in actively promoting misinformation. I will provide some classic examples. It is very common if you listen to the shock jocks in Sydney to hear an alternative medicine or a supplement company call in and talk to Jack or Jill. I am thinking particularly of the vitamin and supplement companies.

You often hear the presenter interviewing someone on the phone and they say that they have a special on this month. They might say, "You can have our vitamins for $90 and they will make you feel so good." The presenter says, "I would not get up in the morning without taking one of these tablets. I have been feeling fantastic ever since you told me about this." They become involved in promoting the product. I think the vast majority would not have a clue. I have often heard Alan Jones reading testimonials about prostate medicines and the like. He is undoubtedly reading from a script and does not have a clue. He has not done any research. If he ever reads this he would probably tell me he has, but I do not think so.

It is reprehensible when the media becomes an active seller. In those circumstances it becomes partly responsible for the misinformation. In an ideal world the media should take some responsibility. It should be brought to the attention of a media outlet that is constantly giving misinformation to the public. The evidence should be coming from an unbiased source. We often get people sending us stuff from the *Women's Weekly* and other magazines with appalling advice given by a naturopath or someone else. Does that magazine have any responsibility?

The Hon. HELEN WESTWOOD: You often get *A Current Affair*-type programs running a similar story. Does Friends of Science in Medicine ever contact the producers of those programs or the *Women's Weekly* to offer an alternative view or a view based on science?

Professor DWYER: Constantly.

The Hon. HELEN WESTWOOD: If you do, what sort of response do you get?

Professor DWYER: We have even offered to supply a column done by one of our executive members. We have an executive member who is a very skilled and experienced nurse. We have offered to have her do a column, but our offer has never been accepted. Mention was made of the *Catalyst* program. We work closely with the *Catalyst* team and I have appeared on the program warning the public about the misinformation that a number of chiropractors are giving in the paediatric area. They have funny theories about subluxation. We worked with the producers on that very constructive program. However, we were shocked to find a few weeks later that they broadcast a terrible program with misinformation about cardiovascular issues. Of course, we had nothing to do with that. We are constantly available. We have more than 1,000 of Australia's leading clinicians and scientists as supporters. We can find some spokesperson for anything and we are constantly doing that to help people.

The other problem with the media—I have often experienced this myself as I am sure Dr McDonald has—is that it will present opposing views as if they are of equal value and the public has no way of working it out. I have stopped debating vaccination with anti-vaccination campaigners because so often at the end of the program the presenter will tell the audience that they have to make up their own mind. They say, "You've heard Professor Dwyer say this and someone else say something else." There is no attempt in the Australian media to provide a balance or to give equal time to equal opinion. If we are going to do that, it requires the media outlet to put some thought into what it is doing. It is useless to put an argument for and against vaccination with no jury except the public. I would rather see other mechanisms and the media paying more attention to that.

The Hon. PAUL GREEN: There is an element of truth in what the supplement providers say. If a person is taking supplements he or she will more than likely have improved health. What is the tipping point of misinformation?

Professor DWYER: I disagree with the premise. The absolute evidence that has been produced, not only here but also around the world, suggests that in western societies like ours supplements should be given only to people who need them. It might be the pregnant woman who needs folic acid, or it could be someone who is alcoholic and who needs vitamin B. The average Australian is chock-a-block full of vitamins. Most of the vitamins we take we cannot store. If you take more of them than you need the body sends them straight down the toilet.

Vitamins, in particular, do not have any therapeutic benefit per se. They do not give you more energy; they do not relieve stress. Recent reports suggest that the average Australian is spending $80 a month on supplements. They do it because they are very interested in trying to maintain their health. However, they do not want to have to do that the hard way by drinking less, exercising more and so on. The wrong message goes out that you can neutralise an unhealthy lifestyle by taking supplements.

The Hon. PAUL GREEN: That is a very good point about the message of taking responsibility for our health through proper nutrition. I am simply saying that there is an element of truth in what they are saying. In some way, shape or form, there are those elements. What is the tipping point for it being misleading?

Professor DWYER: If you move away from universality to target audiences, some people need vitamin D. Older people who do not get enough sunlight certainly need vitamin D supplements. There are also groups of people with a genetic disposition to cardiovascular disease who need folate. There is a whole host of people who are malnourished. In fact, 17 per cent of the geriatric patients coming into New South Wales hospitals are malnourished and need supplementation. The objection is the universality; that is, suggesting that everybody needs them. When you turn on the television in the morning the weather report includes a good little bacteria saying, "Have you swallowed me today?" The marketers are saying that everybody should swallow these good bacteria every day. There is no evidence to support that. It is expensive and it is sending a completely wrong message. We want people to be more responsible for their own health and to improve their health literacy so that they know more about what they need to do to stay healthy. We do not need false messages clouding the issue.

The Hon. PAUL GREEN: Do you believe that every healing can be scientifically proven?

Professor DWYER: No. There is no doubt that modern scientific methods can provide specific answers to specific questions most of the time. However, some things are very difficult to study scientifically and to prove absolutely. We certainly can disprove many claims in scientific studies. Friends of Science in Medicine is at pains to say that it strongly supports research into alternative and complementary medicine where it is not an affront to our knowledge of physiology. You would never want to spend a penny doing research into iridology. It is just an affront to what we know about how the body works.

Much of the medicine we dispense today has been derived from natural therapies. People were using plants and found that foxglove improves heart disease. We found that the active ingredient was digoxin and we purified it. We are all for research if there is good anecdotal evidence that something might be helpful and if the concept behind it is not pseudo-science. We know that many complementary and alternative practitioners limit themselves to offering good advice to people and keep away from the sort of stuff we are talking about. However, time and again the public is let down as you will see if you look at the websites and the information we have provided. Naturopaths are using pseudo-machines that they say can diagnose 24,000 viruses in your body or use light therapy. They work out which colours resonate with your body and if they use those colours they will improve your health. It goes on and on misleading people.

A reporter from the *New Yorker* magazine called me a few weeks ago after I had an article published. I think this sums up the problem. She said, "Look, Professor Dwyer, don't you realise that in this post-modern world people want a more gentle science? They like the idea of working with nature and having a panacea. This is why you are having trouble. You hardnosed scientists are telling people to do this and that." There are some dangerous delusions out there if that is the case. It is true that there are many people who are very interested in the concept. It is our responsibility as clinical scientists to try to improve health literacy and to give people the tools they need to analyse things properly and to make up their own mind. We want people to be more responsible for their health.

The Hon. PAUL GREEN: So healing is not defined necessarily by science, but also by the outcome of the individual chasing a solution to his or her health problems?

Professor DWYER: An awful lot of healing happens because the body is very good at healing itself. Counselling might be able to overcome psychological problems for some people. However, in terms of disease management, sometimes the body cannot heal itself and it is not natural to heal itself. Often someone will take some vitamin C because they have a cold and they get better and say that the vitamin C was fantastic. They were going to get better anyway. The body, psychologically and physically, can heal itself and usually does with things less than very serious illnesses.

It is when you get down to serious problems, and that includes mental health problems, in my opinion St John's wort, which is a very strong antidepressant, should not be available to people unless it is prescribed in the context of a mental health program. People should not be self-treating depression with a tablet. These are the issues. In the future I hope science will see a convergence. There is only good medicine and bad medicine, medicine that works and medicine that does not work. We need science to solve that problem in order to get away from the concept of alternative and complementary medicine. If it is a good technique, if it works and helps people, it should be mainstream.

CHAIR: Professor Dwyer, we are out of time. Thank you for your evidence 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 that we may ask?

Professor DWYER: Absolutely, yes.

CHAIR: Thank you again for appearing before the Committee today?

Professor DWYER: Thank you for your inquiry, good luck with it. As I said, it is timely and important and I am sure good things are going to happen. Thank you everybody, I appreciate it.

(The witness withdrew)

(Short adjournment)

CARL GIBSON, Chief Executive Officer, Complementary Medicines Australia, and

EMMA BURCHELL, Head of Regulatory Affairs, Complementary Medicines Australia, affirmed and examined:

CHAIR: I welcome Mr Carl Gibson, Chief Executive Officer, and Ms Emma Burchell, Head of Regulatory Affairs, from Complementary Medicines Australia. I thank you for appearing before the Committee on the Health Care Complaints Commission to give evidence. Can you confirm 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 GIBSON: Yes, I can.

Ms BURCHELL: Yes, I can.

CHAIR: Do you have any questions about that information?

Mr GIBSON: No.

CHAIR: Would either or both of you like to make a brief opening statement?

Mr GIBSON: Thank you Chair, I will. I thank the Committee for the opportunity today to provide evidence on behalf of the complementary medicines industry. My name is Carl Gibson and I am the Chief Executive Officer of Complementary Medicines Australia, and I am joined by my colleague Emma Burchell, our Head of Regulatory Affairs. It may be helpful to the Committee if I explain a little about our organisation, so that you understand the context of our evidence and the scope of the organisation's expertise. Until early July our organisation was known as the Complementary Healthcare Council of Australia. We recently rebranded to Complementary Medicines Australia. We are the peak body representing the $3.5 billion complementary medicines industry supply chain. That is raw material suppliers, manufacturers, sponsors, importers, exporters, distributors and retailers.

Basically we represent the products rather than the practitioners. However, without informed, knowledgeable and supportive practitioners our industry would not exist and so we are extremely interested in this inquiry into the promotion of false or misleading health-related information or practices. I think it is fair to say that the scope of the inquiry by this Committee has caused a great deal of concern. Many of the submissions received by the Committee warn of an attack on freedom of choice and freedom of speech. Additionally, some of the more forthright submissions question the true motivation of this inquiry and assert that fringe groups such as Friends of Science in Medicine are helping to drive the agenda against education and research in complementary medicines, and using this inquiry as a vehicle to that end.

However, I hope that the Committee is acting in good faith and genuinely wants to protect consumers and not in fact attack the complementary medicines industry. Before providing the inquiry with an update on industry initiatives I want to make some observations on behalf of the industry on the scope of the Committee's inquiry. Let me start by taking a step backwards. It is important that we acknowledge the low risk nature of complementary medicines. Complementary medicines are listed as "low risk" pharmacy products on the Australian Register of Therapeutic Goods. This was highlighted in submission number 21 by our regulator, the Therapeutic Goods Administration [TGA]. Medicines are founded on the principle of "first do no harm" and the plain truth is that no-one has died from using complementary medicines. However, according to the co-founder of the Cochrane Collaboration, pharmaceutical drugs are the third biggest killers in the United States of America and Europe today, after heart disease and cancer.

Now that we have established the relatively low risk of complementary medicines let us look more closely at the number of complaints against the industry. According to submission number 62 by the Health Care Complaints Commission, in 2012-13 the Commission received 4,554 complaints about health service providers in New South Wales and of those 114 complaints were about unregistered health practitioners and 20 complaints were about previously registered health practitioners. Complaints about both groups represented less than 3 per cent of all complaints received during that period. In 2012-13 there were just 10 complaints about unregistered health practitioners for providing alleged incorrect or misleading information. With two in three people using complementary medicines in Australia today I think it is fair to ask, with only 10 complaints

recorded about provision of incorrect or misleading information, is this inquiry a disproportionate one? Should we be asking is this a good use of taxpayer's money?

One could also argue that there is sufficient legislation already in place to address the issue. I refer the inquiry to submission number 48 from NSW Fair Trading, which respectfully points out that Australian Consumer Law [ACL] came into effect on 1 January 2011 and applies in New South Wales under section 28 of the Fair Trading Act 1987. It is jointly enforced by the Australian Competition and Consumer Commission and the State Trading Agency. Under ACL it is unlawful for a business to make a statement in trade or commerce that is misleading or deceptive or would be likely to mislead or deceive. It is worth reiterating the comments in the NSW Fair Trading submission, which points out that there may be overlapping responsibilities between Fair Trading and the Health Care Complaints Commission and there may be cases where the ACL provides a more appropriate power for investigating consumer complaints.

Submission number 30 by the Australian Osteopaths Association reiterated the very same point our own submission sought to clarify, that schedule 3 of the Public Health Regulation 2012, made under the Public Health Act 2010, already contains provisions that directly address false and misleading information and importantly applies to all health practitioners whether or not the person is registered under the Health Practitioner Regulation National Law. Let me now turn to industry initiatives and existing self-regulation. As the Communications Council in their submission number 59 advise, in respect to advertising and PR [public relations] their members have to abide by strict codes set by both government and industry, including Medicines Australia, Australian Self-Medication Industry, Medical Technology Association and our own code, the Complementary Medicines Australia Code of Practice, which has been provided in our evidence pack.

Complementary Medicines Australia promotes industry best practice in relation to the publication and dissemination of technical information to complementary healthcare practitioners, with guidelines and a code of practice. We have published guidelines in cooperation with the TGA to assist sponsors to ensure product guides and technical manuals meet the required advertising provisions. Our members subscribe to our marketing code of practice, which specifically provides that no advertisement should in any way tend to discourage consumers from seeking the advice of a qualified healthcare professional. By law, all advertising for therapeutic goods, including complementary medicines, appearing in specified media must be approved prior to publication. Our organisation acts as the delegate for the Department of Health in pre-approving print advertising for complementary medicines. A comprehensive complaints mechanism is also in place to ensure that advertisements are truthful, appropriate and not misleading. I serve on the complaints resolution panel, which deals with complaints about advertisements for any therapeutic directed to consumers in TV, radio, newspapers, magazines, the internet and in cinemas.

Let me turn to the development of a national code of conduct for healthcare workers. State health Ministers have agreed in principle to strengthen State and Territory health complaints mechanisms with a single national code of conduct for unregistered health practitioners. The Committee will be aware that the Australian Health Ministers Advisory Council has recently undertaken a public consultation on the terms of the first national code of conduct and proposed policy parameters to underpin nationally consistent implementation of the code. The final report will inform the Standing Council on Health, a ministerial council made up of State, Territory and Commonwealth Health Ministers.

Finally, let me turn to industry initiatives that are currently being developed, which may give the Committee further reassurance that the complementary medicines industry is protecting consumers and encouraging greater training and education of practitioners. We advocate for the rights of Australians to have the freedom of choice in choosing their healthcare providers and access to qualified health professionals. Our organisation supports an independent national registration and accreditation scheme for naturopaths, western herbalists and nutritionists.

We are working closely with the TGA, which maintains a schedule 1 list of bodies to whom advertising exemptions apply, to provide a register that mirrors the Federal Government's National Registration and Accreditation Scheme for health professionals. We are working very closely with the TGA, the Australian Register of Naturopaths and Herbalists and the main practitioner associations to develop an effective, independent body for healthcare practitioners. I am confident that this initiative will provide increased confidence to the Australian public that the vast majority of complementary healthcare practitioners practice in a safe, competent and ethical manner.

Our organisation believes that there are appropriate safeguards already in place to protect the consumer from false or misleading information. It is our view that any further inquiry for increased regulatory scope prior to the implementation of the national code of conduct and the ongoing work towards the national registration accreditation scheme would be premature. I trust this opening statement has been helpful in providing context to this inquiry. Thank you.

CHAIR: Thank you, Mr Gibson. I assure you at the outset that our Committee is acting in good faith. In your opening statement you mentioned the national code of conduct for unregistered health practitioners. Could you give us a bit more information? You have given us some information but can you talk about how that might work in practice?

Mr GIBSON: I will pass to my colleague Emma. I should say I am fairly new in the role as Chief Executive of Complementary Medicines Australia. That is why Emma is here with me today.

Ms BURCHELL: Back in 2011 Complementary Medicines Australia provided a submission in support of a national code of conduct for unregistered healthcare practitioners. We have supported the recent consultation that has been undertaken to align a national code of conduct. I believe the national code of conduct would weigh heavily on the New South Wales code of conduct that is already in place and that it would align requirements through the States and Territories and be underpinned by regulations through States and Territories. It would also have the ability to have provision orders made public via its website for any complaints that have been found through the national code process, and that would mitigate areas where some of the codes have found weaknesses in practitioners moving from various States or Territories previously. It is a more efficient code across Australia for unregistered practitioners, so we are very much in support of the principles of that code.

CHAIR: You have endorsed an independent registration system for naturopaths, western herbalists and nutritionists, recognising that some have called for this to protect public safety. What concerns, if any, do you have with certain practitioners of these therapies?

Ms BURCHELL: As Carl mentioned before, the area for which we are seeking national registration for practitioners is in the area of naturopaths, western herbal medicine practitioners and nutritionists, so our focus is very much on the ingestive modalities of complementary medicines. We support that increase in recognition of their qualifications and training as allied healthcare professionals.

Dr ANDREW McDONALD: Can I just clarify, what are "ingestive modalities"?

Ms BURCHELL: A lot of the complementary modalities —

Dr ANDREW McDONALD: Does that mean eaten?

Ms BURCHELL: Consumed, yes.

CHAIR: I am glad you have clarified that, for my benefit as well.

Ms BURCHELL: We see the progression of the national registration for those professions as recognition of their skills and training as allied healthcare professionals and to further acknowledge their standing as healthcare professionals, so we do not have any concerns in those professions. We acknowledge there are a number of other therapies within the range of complementary modalities that may pose other risks, but that is the main focus of our area of advocacy in that space.

CHAIR: You propose that that registration be mandatory rather than voluntary?

Mr GIBSON: We would prefer it to be statutory. However, there needs to be a pathway to get to statutory registration.

Mrs ROZA SAGE: What action can be taken by Complementary Medicines Australia if a member is found to be in breach of its current guideline or codes of practice?

Ms BURCHELL: There are a number of sanctions that can be taken under our current code of practice for members and non-members. Members and non-members alike are encouraged to comply with our code of

practice across the board. If we find that non-members or members have not complied with our code, depending on the risk that may be imposed, we can refer complaints to other State and Territory authorities, such as the Therapeutic Goods Administration, to deal with complaints and we work quite closely with State food authorities in that space as well. We can refer those concerns onwards and we track the outcomes of any complaints that are referred on.

Mrs ROZA SAGE: Mr Gibson talked about representing the product not the practitioners. Who are your members?

Mr GIBSON: We have around 350 members of which 59 are manufacturers, 156 are retailers, also the raw material suppliers, the importers, the exporters, the distributors.

Mrs ROZA SAGE: Thank you.

Mr GIBSON: Also, most fundamentally, the sponsors.

The Hon. PAUL GREEN: Does Complementary Medicines Australia do anything to combat potentially dangerous health-related misinformation in the public domain? If you do, how do you address it?

Mr GIBSON: It is not really within our scope. I was listening to the evidence of Professor John Dwyer a moment ago. We probably have the same view, that if there is anything misleading in the media then we will speak to that media outlet to try to correct that misinformation.

The Hon. PAUL GREEN: But you do not have healthcare people who would make a representation, say, if it was *A Current Affair* or *Today Tonight*, for example? You do not have a bank of people that you—

Mr GIBSON: We do. We have a panel of eminence but not in the same league as the fringe group Friends of Science in Medicine. We only have 20 people.

CHAIR: You would not normally comment on activities or behaviour of people outside your membership group, would you?

Mr GIBSON: No, it is not within our scope.

Dr ANDREW McDONALD: Have you read the submission of the Australian Medical Association?

Ms BURCHELL: Briefly, yes.

Mr GIBSON: I actually read all of the submissions.

Dr ANDREW McDONALD: They have asked that section 7 of the Act be amended. At the moment own-motion complaints are likely to affect only the clinical management of care of an individual client. They have asked that it be amended to affect the clinical management of care of the public or any member of the public. This is about trying to cover groups such as the whole-body screeners who advertise whole-body CT scans as a way of identifying healthcare problems, for which there is no scientific basis and gives a high rate of false negative results. It is not aimed at the complementary medicine industry. How does your organisation feel about such an amendment?

Ms BURCHELL: In general, Complementary Medicines Australia has been part of the whole-of-government review—therapeutic products review—which looked at high-level principles for all codes of practice, including Complementary Medicines Australia. We were involved in that early work and we have revised our code to increase with those high-level principles, so any further revisions to codes of practice in that scope would certainly—

Dr ANDREW McDONALD: This is the Act. They have asked the Parliament to amend the Act rather than the code.

Ms BURCHELL: Yes. I do not have any concerns with whole-body screening or devices in that regard.

Mr GIBSON: It is probably outside our scope. I would suggest a conversation with Dr Wendy Morrow.

Dr ANDREW McDONALD: Can you see such an amendment having any adverse effects on your group? I cannot; I just wondered whether you could.

Mr GIBSON: No, I cannot.

Ms BURCHELL: No, we support the protection of public health or members of the community in that regard.

Dr ANDREW McDONALD: Not all groups are registered, I understand. Social workers are not registered with the Australian Health Practitioner Regulation Agency [AHPRA] and they are widely respected.

Mr GIBSON: That is so.

Dr ANDREW McDONALD: You do not need to be registered to be a credible allied health professional; having said that, social workers want to become registered. Are you in that group of people who feel that registration is to the benefit of public safety as well as the professionals?

Mr GIBSON: Yes. The reason the debate opened up again regarding the national registration scheme is because the TGA put out a consultation on advertising to practitioners. Some of the information that gets to practitioners is technical and scientific in nature, but as they are not recognised as healthcare professionals, they are treated as members of the public. Therefore, that information would have been restricted, thus taking away the tools for them to do their job and having the latest knowledge to inform patients.

Dr ANDREW McDONALD: You talked about the broad facets of the code of conduct. In simple layman's terms what is your idea of what the code should represent to a member of the public?

Ms BURCHELL: What our code of conduct should represent to the public?

Dr ANDREW McDONALD: Yes, in *Daily Telegraph* three dot points.

Ms BURCHELL: Our code of practice is looking at establishing high-level principles and industry endorsed best practice in the appropriate quality use of complementary medicines for the protection of consumers. That would be the nature of marketing these products directly to the general consumer or to the healthcare practitioner, which also comes under our area.

Dr ANDREW McDONALD: It means truth in advertising?

Mr GIBSON: It probably helps if I can translate into *Telegraph* speak—

Dr ANDREW McDONALD: Yes, please.

Mr GIBSON: —which is: do not deceive or mislead.

Mrs ROZA SAGE: Following on from that, do you think there should be more regulation of digital and below-the-line advertising, which currently exists for television and radio media, which is outlined in your submission?

Mr GIBSON: There is an interesting debate at the moment about the Federal Government's view of deregulation, whether or not we deregulate the whole of the pre-approval system for complementary medicines where advertisers are actually technically guilty until proven innocent. Their adverts have to go through a very comprehensive and rigorous approval process, whereas it could actually sit under the Australian Competition and Consumer Commission [ACCC] where you would get the review after a complaint to see if it was deceptive or misleading. It is fair to say at the moment that the consultation that will be happening pretty soon about the future of advertising of complementary medicines and how that sits—

Mrs ROZA SAGE: Which way do you think would be the better way to go: being proactive or being reactive, after the fact?

Mr GIBSON: For our organisation it is very difficult to have an opinion because some of our advertisers would prefer the existing system be reformed and some would prefer it to be abolished because they view it as a regulatory hurdle.

The Hon. HELEN WESTWOOD: I was interested in your previous answer that if a member is found to have breached the current guidelines and the codes you would refer them and your concerns to an appropriate authority. How many such referrals have you made in the past 12 months or the past five years?

Ms BURCHELL: I would probably have to take the actual numbers on notice. We do report those in our annual report. They will specify for you member versus non-member numbers to them as well. Quite often we will also receive complaints that should have been more appropriately dealt with by the regulator in the first instance. So there is a fair bit of referral that occurs there just from having multiple mechanisms for making a complaint in the first place. It is an area that consumers and others get quite confused over. But we absolutely take what can be dealt with in house and in the scope of the committees that we have and we delegate those or pass them on to Food or the Therapeutic Goods Administration, as required.

Mr GIBSON: We will take that on notice and I will come back to you with the statistics for the last five years.

The Hon. HELEN WESTWOOD: Thank you. Could you describe the complaints handling process to the Committee? Who are they received by and is there self-reporting by the organisation? Do you monitor it or do you wait until you receive a complaint and, if you do, how do you process that to the point where you refer it to another authority?

Ms BURCHELL: Our marketing code dictates the time frames in which once a complaint is received the communication occurs from our organisation to the complainant. We encourage in the first instance that any issues are dealt with from the party making the complaint and against the either member or non-member that it affects. If that does not occur we have a process where a committee meets on the complaint and can make a determination. There is a broad spectrum of stakeholders on that committee. There are appeal mechanisms within that committee and associated time frames to then appeal against any decisions that are made in that process and all those reportings are made by the annual report at the end of each year.

There are set time frames for in line of those processes and whether the code is achieving its stated objectives, looking at the number of complaints and whether it is having its stated objective in achieving greater compliance within the industry. As I briefly mentioned, there is also the review of our code in line with the high-level principles that the Government's working group on the Promotion of Therapeutic Products is looking at underpinning those codes of practice to a greater detail as well.

The Hon. HELEN WESTWOOD: You said the committee is made up of key stakeholders. Who would they be and is there a consumer representative on the committee?

Ms BURCHELL: Yes. It is made up of about five to six Complementary Medicine Association members, the executive director, a consumer representative and a healthcare practitioner representative. It can have an independent body in there as well and the Therapeutic Goods Administration as an observer. There is quite a broad stakeholder representation.

The Hon. HELEN WESTWOOD: How do you report the outcome of the complaints? Is the detail of a complaint in your annual report?

Ms BURCHELL: We have a register, which is a system that details where the complaints are up to and the outcomes of those complaints. The code of practice is seeking to make aspects of those complaints more transparent on our website as well.

Mrs ROZA SAGE: What sort of penalties are there for those who break the code? I know pharmaceutical companies get huge fines for misinformation. What sort of penalties are there for your members?

Ms BURCHELL: Our members can be expelled from our membership as a sanction. For any sort of vexatious complaints that are put to the committee we can see that fees are paid back to us for the cost of time

and travel, et cetera, for the committee meetings. Where we are dealing with behaviour of a perhaps more misleading nature, those would be the types of complaints that are referred on to other regulators for dealing with them. Then that comes under their sanctions.

Mrs ROZA SAGE: Which regulators would you normally send these complaints to? Does it depend on what they are?

Ms BURCHELL: It does depend on the nature and there is quite a crossover between a food and therapeutic goods interface for some of these complaints. That is why we have the NSW Food Authority, for example, or other food authorities and the regulator participating in the deliberations.

CHAIR: Professor Dwyer talked about, amongst other things, the overuse of vitamins and how they should be targeted at people who have or are likely to have a vitamin deficiency. Do you agree with his comments or do you think that vitamins should be taken generally, regardless of any likely deficiency?

Mr GIBSON: I actually agree with Professor Dwyer that vitamins play a role in helping supplement but they are purely a supplement. We encourage people to have a good diet, good exercise and supplement where required. But I think the truth is that three-quarters of the population of Australia is not taking good exercise and is not having a good diet. We disagree on numbers but we agree with the positive outcomes.

CHAIR: What about his comments on the media in relation to promoting self-diagnosis for supplements and other treatments? Do you agree that there is a role for a more responsible media and, if so, do you see your organisation playing a part in that?

Mr GIBSON: Again, our organisation is focused on the products rather than the practitioners. But I passionately believe Australians should take self-control of their health. More information and more knowledge in the marketplace is a good thing.

The Hon. PAUL GREEN: In terms of this inquiry, what sort of recommendations would you propose?

Mr GIBSON: I am rather hoping that this inquiry will actually pause for a while until we see the development that happens with the national registration and accreditation scheme, and also the code of conduct. I think I would like to see what developments happen there first.

Dr ANDREW McDONALD: At page 17 of your code of conduct section 8.7.1 states that travel may be provided. Is that common? The context is that one of the unethical drug companies flew every gastroenterologist in Australia to Switzerland to get them to prescribe a newer proton-pump inhibitor that was inappropriate. So Big Pharma has form here. What I am asking is whether getting specialists or various people to go around the country at the expense of the industry is common.

Mr GIBSON: No. I see your concern entirely but it is not very common in our industry. I think I should declare I was flown to Alice Springs once. That is about the extent from my one year in the role.

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

Mr GIBSON: Very happy. We are also happy to supply the statistics we talked about.

CHAIR: Thank you for that and for appearing today before our inquiry.

(The witnesses withdrew)

KIERAN PEHM, Commissioner, Health Care Complaints Commission, sworn and examined:

CHAIR: Thank you for appearing before the Committee on the Health Care Complaints Commission to give evidence. Could 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?

Mr PEHM: Yes, thank you, Mr Chair.

CHAIR: Do you have any questions about that information?

Mr PEHM: No.

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

Mr PEHM: I have made a fairly detailed submission to the Committee. It is clear from the other submissions that have been made that this is a highly contentious area. On the one hand, pretty much advocates of free speech are suggesting there should be no restriction at all and, on the other, there are people who are quite passionate that harm is being done by the promotion of false and misleading health information and products. It is quite a complicated regulatory landscape. A large proportion of complaints in this area are really consumer complaints in that there is no harm to the public, and the Commission's mandate is to protect public health and safety. There are a small proportion of complaints that may cause public harm and we have suggested some very conservative possibilities for the Committee to consider in relation to our legislation. I am happy to take questions.

CHAIR: Your submission states that only a relatively low number of complaints were made about the provision of incorrect or misleading information in 2012-13. Is this due to lack of awareness by consumers that they can contact the Health Care Complaints Commission [HCCC] or is it that it is not a major issue?

Mr PEHM: It is always hard to say. We do not know why people do not complain because we do not have any information about that. I think by and large the interactions with—to use a generic term—alternative health providers do not cause harm. The sorts of products they are purveying do not damage complainants' health and so the propensity of complaints is probably lessened by that in that no serious harm is suffered. There are other consumer complaints that they were overcharged or that the treatment was useless but they paid money. But, really, we cannot answer why the number of complaints is so low. It could be either that they are not too concerned about the harm caused or they are not aware of the avenues of complaint.

CHAIR: Has there been any significant change in the number of complaints that have been made to the HCCC in recent years?

Mr PEHM: There has been a very low increase over the last five years from 71 in 2009-10 to 125 in 2013-14. That figure also includes assistants in nursing institutions and practitioners, so it would be an even smaller number than that. The code of conduct for unregistered practitioners was brought into force I think in August 2008 and the Commission did quite extensive consultation with the peak representative bodies of naturopaths and acupuncturists and so on at that stage, and those bodies have also promulgated information to their members. That probably explains the rise. But, as you can see, it is not an avalanche of complaints; not a huge number.

CHAIR: What about the complaints that come in but fall outside your jurisdiction? Have they been increasing?

Mr PEHM: No, I cannot say they have been increasing. One case that was probably one of the impetuses for this inquiry was the Australian Vaccination Network. But, no, there has not been a general increase in complaints about the provision of false or misleading information.

Mrs ROZA SAGE: We have been hearing about many different types of alternative types of medicine that have been causing some concern within the community. With the amendment in the legislation of section 7 of the Health Care Complaints Act, have you been acting more proactively on some of this misinformation?

Mr PEHM: Wherever we have jurisdiction we will act and assess the complaints and investigate them under the Act. We also have an own motion power, but that is conditional on the complaint raising a significant issue of public health and safety or involving disciplinary action against the practitioner. So it is a fairly high threshold. The complaints generally are not by users of these health services, if you want to call them that; they are generally by passionate advocates and people who philosophically disagree with the service they are providing. We primarily deal with patient complaints and we have not seen any serious cases of patient harm being caused. That would be the main area that we would investigate. Misleading information or people buying products under false pretences is really a consumer affairs sort of issue, and there are extensive provisions there with the Department of Fair Trading and the Australian Competition and Consumer Commission that deal with those sorts of areas.

Mrs ROZA SAGE: We have also heard that there has been collaboration with some of these other agencies—Fair Trading, the TGA and so forth. Do you feel that there should be a more formal sort of arrangement for this—an interagency committee?

Mr PEHM: I think I mentioned that in the submission. I do not think that is at all a bad idea; it would provide a forum for issues to be raised and continually monitored and ventilated. I think it is a good idea.

CHAIR: We heard evidence from Professor Dwyer earlier today in relation to qualified doctors and, in some cases, specialists who actually refer patients to unregistered and alternative healing people. He made the comment that when people complain to the HCCC about that the HCCC states that these specialists and doctors are only expressing an opinion by referring them on and, therefore, the matter does not go further. He said, "The HCCC is crippled by a lack of capacity to act". Do you feel that by broadening and strengthening your powers you would be in a better position to be able to address the issues?

Mr PEHM: I am not sure what the basis of that statement is. The Commission has the power to investigate the professional conduct of a health practitioner—that includes their treatment and care to patients but also issues like character and whether they are suitable people to be registered as practitioners. So I do not see an issue like referral to alternative practitioners would be outside our capacity to inquire into now. It probably comes down to that issue again of harm and what the damage is to the patient, whether it is a significant issue of public health and safety in terms of whether we would investigate or prosecute a practitioner for that.

A practitioner simply saying, "Here is an alternative health practitioner you might want to see", and it then being the patient's choice—although being influenced somewhat by the referral—would never be sufficient to take disciplinary action against a medical practitioner, which is the case we are talking about, to affect their registration. It is conceivable that if it was done deceptively or undue pressure was put on a patient to see an alternative practitioner or the medical practitioner was getting some sort of financial reward for referring, that is a matter that may well get up to disciplinary action. We have not had complaints of that seriousness in this area.

CHAIR: You have not had any complaints from patients?

Mr PEHM: There is one complaint that I can think of. In that matter the practitioner was referred to the Medical Council—we are in a co-regulation arrangement with the Medical Council. In a situation like that the council would look at counselling, which may involve calling the practitioner in for an interview, discussing the reasons why they make referrals and their relationship with these other entities. That matter did not get up to a level that was serious enough to prosecute the practitioner and look at somehow limiting their registration.

CHAIR: Professor Dwyer also made the point that the way the legislation is written at the moment you tend to be reactive—you are a complaints receiving body—and in his view he would like to see the HCCC being more proactive, not just the HCCC but the TGA as well. Do you share that view that you might be able to reduce levels of harm potentially by having additional powers to be more proactive?

Mr PEHM: I think he is basically correct to say we are reactive in that we respond to complaints. We do have an own motion power. So if we get a number of complaints in the area we can go further, but we certainly do not go out looking for the sorts of issues Professor Dwyer is interested in to launch investigations. There is a number of reasons for that. We do not have powers of compulsion so far as organisations are concerned—the AVN [Australian Vaccination Network] is a good example. We investigated their publication, we acted to the limits of our powers within the Act and we ended up publishing a public warning about what they did, but they are still publishing the anti-vaccination information that they believe the public should know

about. We have no power to compel them to do otherwise; we cannot make orders prohibiting them from doing that or seeing that they be prosecuted for offences for doing that.

So our powers are limited. It is a matter for government as to whether it is prepared to legislate to provide a body with the sorts of remit and powers that Professor Dwyer would like. In making that decision I guess you have got to look at the scope of the problem—theoretically, it can be quite big. The evidence we have in terms of complaint numbers does not suggest huge public harm being caused and maybe, as your opening question suggested, there are a lot of hidden issues out there that are not being addressed and it may be that an investigatory body could dig into those issues and find something. That is all quite speculative and at the moment we do not have the power to do that.

We can dig into it and look but in the end we cannot make compulsory orders prohibiting these people from disseminating this information—and they are very passionate about it. There is no question that they will continue to do it and you have to realise that, if a similar scheme to the unregistered code is adopted, ultimately a breach of a point of our order can be prosecuted in the local courts. There is no doubt a lot of these groups would see that as a badge of honour and welcome the prosecution; they would be quite happy. I do not think it would change the information they are putting out in the case of organisations like AVN, for instance.

The Hon. PAUL GREEN: There has been some discussion about issues concerning jurisdiction, particularly internet-based organisations and their domain. What problem have you encountered with respect to that?

Mr PEHM: We had one case, which I refer to at the back of our submission, where it turned out that the purveyor of the information that was of concern to the complainant was not a health service anyway so we would not have had jurisdiction. But some inquiries were made by another agency and that internet site was based in South Australia. Internet publication vexes everyone from the High Court down. Where is the offence committed? Yes, it is published here but we have no jurisdiction to serve notices in South Australia and no powers to compel people from South Australia to give evidence, so an investigation would be very difficult. There are a lot of problems with the internet—it is everywhere, but our power is in New South Wales.

The Hon. PAUL GREEN: Is there any part solution to this?

Mr PEHM: I do not think there is really. I think it is just one of those platforms of technology that has outgrown the traditional methods of lawmaking and law enforcement. Some European countries are taking a very strict view: If it is obviously published in our domain then they have the power to compel, but it is a completely different legal structure and they have cooperative arrangements between countries to establish jurisdiction. In Australia, as a New South Wales public authority we would have great difficulty investigating, in practice, something based in another State. Even if we could investigate, and suppose they voluntarily gave us all the information and we decided it was a breach of the code of conduct, for argument's sake, and if we then make an order prohibiting them from publishing that in New South Wales, they could still upload it on the internet in South Australia. It would exist in New South Wales and then it would be a test case as to where the publication was and, if so, whether they are committing an offence in New South Wales by publishing in South Australia. All those legal questions are up in the air.

Dr ANDREW McDONALD: The AMA has put in a submission. I do not know if you are familiar with the recommendation.

Mr PEHM: I have not had a chance to read it.

Dr ANDREW McDONALD: I know your submission is six months old, so correct me if things have changed since then. Theirs is also six months old. They have asked that section 7 of the Act about the own motion complaints, when the complaint affects the clinical management of care of an individual client under section 7 of the Act, be amended so that a health service, whether registered or unregistered, which affects or is likely to affect the clinical management of care of the public or any member of the public—that is a wide arena. Effectively, that is aimed at the cancer screening groups that are advertising to do this. I know you have an issue with that.

Mr PEHM: The whole body screening.

Dr ANDREW McDONALD: Has that amendment been passed? If not, can I have your opinion on whether it would be a good thing?

Mr PEHM: I think the law currently gives us jurisdiction if the service not only affects the treatment of the client but is likely to affect the treatment of clients. That amendment came in after the AVN court case. Theoretically, we could investigate those agencies—

Dr ANDREW McDONALD: But you have not.

Mr PEHM: We have not formally investigated, but we certainly made inquiries into a number of them. It is not just whole body scans. There are things like doctors internet prescribing, where they will prescribe drugs for common sorts of conditions, high blood pressure and so on. They have procedures that ameliorate the risk, if you like. People fill out questionnaires, they look at the risks. If there is any risk they have doctors and the doctors will contact the patient. If anything is outside the norm levels they will say, "See your practitioner if you don't want to use the service". The body scan people are different. There is a real question over whether they are even health service providers. We have had legal advice—

Dr ANDREW McDONALD: They are not because they are not registered practitioners.

Mr PEHM: Exactly. Is it a health service? There would be a real question over that. Again, their service is saying, "Well, we provide a technical scan, a report is generated, you have high levels", or "There's a shadow there that needs to be investigated. Take this to your practitioner and talk to them." The AMA has raised a couple of hypotheticals where a patient, for example, might get a scan and say, "The scan says I'm all right so I don't have to see a doctor". That is possible. Again, even if you accept that in reality the potential risk was a significant risk to public health and safety, we would then have a problem with another health service provider. We would have no capacity to make orders about that because they are an organisation.

Dr ANDREW McDONALD: At the moment they are putting flyers in letterboxes, advertising these for $800.

Mr PEHM: I got one.

Dr ANDREW McDONALD: It causes every person damage because the amount of radiation is significant—the same as 300 chest x-rays. It is not a safe procedure. It costs about $800 and has a high rate of false negatives and false positives by a non-registered practitioner. Would the AMA amendment to the Act give you greater cover?

Mr PEHM: I do not have the text of their amendment.

Dr ANDREW McDONALD: I have one. Here is one I prepared before.

Mr PEHM: I see. So they want to just change the wording to affect the treatment of a client, like it could affect the treatment of the public or any member of the public.

Dr ANDREW McDONALD: Yes, and that basically means that you do not need Kieran Pehm to be found to have lung cancer next week.

Mr PEHM: I would not have a problem with that amendment. I do not think it answers the whole problem though—

Dr ANDREW McDONALD: No, but I agree it is an improvement. It is not perfect but it is an improvement on what we have.

Mr PEHM: We still have the issue of whether they are a health service provider. I think the definition of a "health service provider" is unnecessarily narrow.

Dr ANDREW McDONALD: They would be treated as unregistered practitioners, which means that somewhere in Sydney there will be places doing these scans.

Mr PEHM: Yes, and we might have power over an individual if you said it was a health service and the individual doing the scan is providing a health service and, on your argument, the radiation level is high and harm is caused. However, we would have no power in terms of making any orders about the organisation.

Dr ANDREW McDONALD: Would that amendment—

Mr PEHM: No, because it would still be an organisation. All we can do in relation to organisations is investigate and, if we are satisfied at the end of that, make a public warning. We might make a public warning that the radiation levels are high. I would be interested to see their promotional material because there is a huge market out there for this stuff. These are commercial people and what they will do is say, "The scan will give you significant radiation if you have any conditions before you do it". Then again it is back to consumer choice. They are very sophisticated operations and I do not think it is a simple legislative amendment.

Dr ANDREW McDONALD: Would that amendment have helped in submission 62A where No Fluoride Australia—that was the one that you kept confidential about No Fluoride Australia, where—

Mr PEHM: No, because our Crown Solicitor's advice was that that is not a health service.

Dr ANDREW McDONALD: Under that amendment it would not have to be a health service.

Mr PEHM: There is a complaint about a health service, whether registered or unregistered.

Dr ANDREW McDONALD: Yes, they are providing a health service.

Mr PEHM: Sorry, I took it from—

CHAIR: Can we take up the issue of the "health service" definition at the moment? It seems to be quite central. From what I am hearing, you are saying that the current legislation is unnecessarily restrictive and prescriptive and you would prefer to see legislation along the lines of the Queensland Ombudsman and maybe the Privacy Act so that you have a capacity to investigate health providers who are currently not able to be investigated because they are outside the definition of a "health service". Am I reading you correctly?

Mr PEHM: That is the gist of it, yes.

Dr ANDREW McDONALD: Under the legislation that will allow you to investigate groups like No Fluoride Australia, which is not a health service under the current legislation. What amendments would be required?

Mr PEHM: I think there will always be people who comment on health matters that are not health service providers. I think No Fluoride Australia is. They are putting out information that relates to a health issue, but they are not describing themselves as "health service providers". That is where AVN was caught because its articles of association said, "Our role is to educate the public about matters of health". But there will always be people who comment on things on the internet and anywhere else who will not be health service providers just because they are commenting about those services. In a sense, even if you made the broad definition of a healthcare worker or any service that affects the health or welfare, there will always be people making commentary who would not be health service providers. I suppose the test would be that the public would have to perceive that they were acting in their health or welfare, but it is by no means clear and there will always be grey areas.

What I am suggesting is that the grey areas would be lessened. At the moment the definition is health as in medical, dental, nursing, alternative health services and then social welfare services necessary for anything above. All of these body scans and these newer things do not fall very easily into the definition. I would rather have the Commission not fall at the first hurdle and say, "We can't even be satisfied it is a health service. Let us at least get it over the hurdle and then we can look at the risk to public health and safety." Even if the definition changed, no doubt people will challenge us and say, "Well, we are not a health service" and it may have to be settled by a court at the end and look at the definition. But that is what I am saying. It should at least have a potential to be brought in so we can examine the substance of the complaint, rather than it just falling over on the jurisdictional issue.

Dr ANDREW McDONALD: At the most basic level these body scans are not a health service so they are falling through.

Mr PEHM: We did not get formal legal advice on that but on the legal advice we have on other cases I would think not at the moment.

The Hon. HELEN WESTWOOD: I turn to Fair Trading, because we had Fair Trading NSW in yesterday. Many submissions as well have talked about Fair Trading and they have stressed the need for the HCCC and Fair Trading to work together more closely on overlapping matters, including entering into arrangements for information sharing and the capacity to initiate joint investigations. Can you talk to the Committee about the present relationship between the HCCC and Fair Trading?

Mr PEHM: We refer matters to one another regularly. We have done joint investigations. We have no formal MOU, but we both have powers under our respective legislation to disseminate information and cooperate. So the relationship is on an as-needs basis when an issue comes up that might cross the jurisdictions. There was one case—it is going back a bit now—where our officers and Fair Trading jointly executed a search warrant on an unregistered practitioner because we both had jurisdiction. Fair Trading also took action on the AVN issue. So there is certainly cooperation there. It is a satisfactory working relationship.

The Hon. HELEN WESTWOOD: One thing that was suggested to the Committee yesterday is that since the Food Authority has been established and it has broader powers around food, it is able to deal with those complaints, investigate, regulate, take action. That would be an appropriate model for the HCCC to expand its powers, so the HCCC rather than Fair Trading would deal with all health-related matters in the same way that the Food Authority does now.

Mr PEHM: That is Fair Trading's submission.

The Hon. HELEN WESTWOOD: Do you have a view?

Mr PEHM: Yes. They have a tendency, once they see anything with "health" on it, to refer it to us. I am not really familiar with the Food Authority, but they do have a much more proactive role. They are inspecting and testing, and it is a very different model. If we were to get into this area, as Professor Dwyer is suggesting, of being proactive and active and out there without complaints, it is a big job. It is a different sort of organisation in a sense. I mean, there are issues of funding for one.

The Hon. HELEN WESTWOOD: I think we would accept that about resourcing, but is there any inherent conflict between the role that the HCCC has now and the powers being broadened to then have the same role and the same model of organisation and power as the Food Authority?

Mr PEHM: No, I do not think it would be a conflict. It would be more like an extra tranche of work. Our initial jurisdictional work was about health consumer complaints and registered practitioners. That has been expanded in 2008 to unregistered health service providers, which is a new area of work. There is not really a conflict, but we would probably need a different sort of team or section to deal with that sort of thing, with different sorts of skills and getting out there and inspecting and getting familiar with the area and so on. No, it is not impossible or against the charter. The Commission's charter is in the legislation so the Government can determine what the HCCC does.

Dr ANDREW McDONALD: Professor Dwyer suggested that the HCCC be called the health consumer protection commission, which is widening the remit. As you said, it started to investigate problems with registered practitioners and now it has a wider remit. Should we continue to widen that remit so that the HCCC can be—which in many ways it already is—a consumer protection commission?

Mr PEHM: I think if we did get that extra jurisdiction you might look at a change of name. I think the danger with the health consumer protection moniker is that the registered practitioners would see that as, "Well, you're on the consumer's side." We would maintain, presumably, our major jurisdiction of investigating complaints against practitioners, and that is a very sensitive area. We would not want a name that suggested we were consumer advocates when we are investigating health practitioners.

Mrs ROZA SAGE: Do you have referral arrangements with the TGA?

Mr PEHM: We do refer matters to the TGA. We are aware of their jurisdiction and when complaints come in we think would be better dealt with by them, we refer them to them, or we say to the complainants, "You can go to them." Complainants often go to multiple agencies in these situations. TGA complaints are rarely by consumers. They often are by the competition—someone is using a new product. It is a different sort of regulatory framework. They are not often consumer complaints, but there is exchange of information. We do not have a formal memorandum of understanding [MOU], but we have the power to refer matters to them and we do.

Mrs ROZA SAGE: Do you have an MOU with Fair Trading?

Mr PEHM: No, we do not have an MOU. We did start drafting one a couple of years ago. It was never finalised. It is not legally necessary. An MOU is just an understanding of what you will do. We have the power to refer matters to them and we do and we work jointly with them when the case arises. All an MOU would do would be to express that in writing.

Mrs ROZA SAGE: Returning to my earlier question, you think there is benefit in having an interagency committee. Which agencies would you think would be best to work with?

Mr PEHM: The interaction between the consumer protection agencies and healthcare agencies, that is the major interface. I think the Food Authority. The TGA would be relevant. There is the pharmaceutical services unit of the health department as well that investigates pharmaceutical products. They are issues with importation and non-TGA approved products being disseminated to the public. As you can see, it is a fairly complicated regulatory landscape. I think anyone who had a stake in the issues should be represented. It would allow each of the agencies to flag issues that come up through complaints or other means and say, "Is this a matter for you?" or "Has this come up through your processes? Are you doing anything?" I suppose it has the potential to be a little more proactive than just on receipt of a particular issue going to them and saying, "Let's cooperate on this particular issue." It would be a forum for airing of more general issues. I think it would be useful.

CHAIR: I refer to the issue of public statements under section 94A. When a statement is made in this way, how is it publicised by you?

Mr PEHM: We publish it on our website and we issue media releases. We have a list of 120 media outlets that we send it all to. That is probably as much as we can do.

CHAIR: The Committee has received evidence suggesting the creation of a public warning register. Would the Commission consider that? In other words, doing it at the beginning of an investigation rather than after if, prima facie, the evidence appeared to warrant a public warning?

Mr PEHM: When the same issues occur for us, we can only issue it at the end of an investigation. There are a whole lot of procedural steps. They call it procedural fairness. An investigation can take some time. There may be cases where a more urgent public warning is appropriate. I am not sure about the idea of a register. I suppose the issue really is public access to the information—nowadays, just google. They will just type in the name of the provider they are concerned about and it will pick up. I am just not sure how and what form a register would take or what further power it would have than just publishing it on our website.

Dr ANDREW McDONALD: Should the HCCC be able to issue interim warnings when an investigation is on foot and not yet finalised?

Mr PEHM: We have that power. Well, it is not power to make warnings, but in relation to unregistered health individuals.

Dr ANDREW McDONALD: No, to stop them.

Mr PEHM: We can issue an interim order that we think it could be so serious that we do not want to wait until the end of the investigation.

Dr ANDREW McDONALD: That brings me back to the cancer screening and CT screening issue. Clearly, at best it is expensive and not particularly useful—in other words, dangerous. This is something about which you could actually issue an interim warning because this is not a registered practitioner and you are the

Health Care Complaints Commissioner. What powers do you need to be able to have the Health Care Complaints Commissioner put out a press release to 120 people saying, "Do not do this because it is useless"?

Mr PEHM: Again, that goes to the point you raise about being proactive and reactive. At the moment we would need a complaint. We would have to investigate a complaint and finally make the warning.

Dr ANDREW McDONALD: You have received complaints about these, but you said it is not an organisation so you cannot actually do anything about it at the moment.

Mr PEHM: I do not think we have even had a formal complaint about these. The AMA just raised it. What I have said to them is, you know, make a complaint.

Dr ANDREW McDONALD: You just need a patient to complain? I can get you one.

Mr PEHM: We do not even need a patient to complain.

Dr ANDREW McDONALD: A person can complain?

Mr PEHM: You need a complaint.

Dr ANDREW McDONALD: You need a complaint from a person who has received one of these?

Mr PEHM: Yes. But the Fair Trading Commissioner can issue warnings on consumer products. I am not sure what the prerequisites are, whether they have to formally do investigations, but maybe that power to just make a public warning about a dangerous consumer product without the necessity—

Dr ANDREW McDONALD: But this is health, so it really does not have that expertise.

Mr PEHM: No, but as a model. I am thinking perhaps the Commissioner—

Dr ANDREW McDONALD: The Health Care Complaints Commission has the expertise and credibility to be able to something such as this.

Mr PEHM: Yes. I am thinking of the type of legislation you might put in the Health Care Complaints Act to allow us to make public warnings. I suppose just talking about it, the question is whether there is a need for a formal investigation at all. If some things are so self-evident, should we just have a general power to make public warnings?

Dr ANDREW McDONALD: Yes. Do you mean legislative changes?

Mr PEHM: It has only just occurred to me. It sounds like a good idea at the moment. There would be procedural fairness issues, obviously, to the organisation you are making the warning about.

Dr ANDREW McDONALD: Yes.

Mr PEHM: There would need to be appeal rights for them.

Dr ANDREW McDONALD: This is one where there is clear evidence of adverse results.

Mr PEHM: That is another issue you would have to look at. Are you making it against the individual health service provider? At the moment it is the complaint against, if I call it Body Scan, for instance, there might be four or five other companies doing the same thing.

Dr ANDREW McDONALD: Yes. So you could make it overall.

Mr PEHM: The other problem with the organisation is if we issue an order against Body Scan, change your name to Full Scan.

Dr ANDREW McDONALD: In theory, could you issue a public statement saying "Full body unreferred CT scanning is inappropriate"?

Mr PEHM: What you are talking about is a practice rather than a health service provider.

Dr ANDREW McDONALD: Is that currently outside your remit?

Mr PEHM: Yes.

Dr ANDREW McDONALD: You need legislative change for that?

Mr PEHM: You would.

CHAIR: Your submission refers to Fair Trading's powers under the Competition and Consumer Act to "prohibit deceptive or misleading conduct" and has extensive sanctions including warnings, bans and criminal prosecutions. Would the HCCC consider such tools at its disposal to be useful in similar instances of misleading and deceptive conduct by a health-related organisation? What other powers should be afforded to the HCCC?

Mr PEHM: I have been looking at this in terms of it having a power to address a problem and you would not want to duplicate the power in another agency. If there is one agency to address it, then it should be able to address it.

CHAIR: Although on that point, if they are referring everything to do with health to you, they are not investigating it particularly where there is no purchase of a product.

Mr PEHM: Yes.

CHAIR: So there is no offer and acceptance arrangement.

Mr PEHM: That is right.

CHAIR: That definitely is a case for the HCCC, is it not?

Mr PEHM: That is again if it is identified. If there is no consumer relationship, they would have no power. That is where these broader issues and broader provision of information come in. Yes, again, it is just coming to me fresh. This cannot really be giving you a considered view, but those sorts of powers you would look at as possibly a model if you wanted the Commission to pursue that area.

The Hon. HELEN WESTWOOD: In your submission you mention that under section 99 of the Public Health Act you have the power to prosecute a person for advertising or promoting the provision of a health service in a manner that is false, misleading or deceptive. How many prosecutions has the HCCC pursued under this legislation, if any?

Mr PEHM: We have not done any. I will have to have a closer look at that. When we did this submission we just surveyed all the landscape of potential applicable legislation. It is not the Commission's role to enforce the Public Health Act.

The Hon. HELEN WESTWOOD: Would not having the power or role be the limitation?

Mr PEHM: Our powers are in the Health Care Complaints Act. I think what we are saying there is that any person can bring a prosecution.

The Hon. HELEN WESTWOOD: Under that section?

Mr PEHM: Yes. Theoretically, at law any person can. A member of the public can.

The Hon. HELEN WESTWOOD: If a member of the public can, could not the HCCC?

Mr PEHM: Yes, we could theoretically. But we are more likely to get the matter as a complaint—deal with it as a complaint. As I say, our complaints have never got to that level. It is a big area. There is a section there that points to address it, but there is not really a mechanism for enforcement. We have not done this. It would be a big accretion of jurisdiction for us to take on that job.

Mrs ROZA SAGE: In your submission you have canvassed also another option where unregistered health practitioners are prosecuted before the Civil and Administrative Tribunal with the HCCC as a prosecutor. Could you give us more information and elaborate on that suggestion?

Mr PEHM: The current situation is that the Commission can make an order saying to an unregistered practitioner, "You can't practise at all." If the practitioner breaches that order, we can then prosecute them before a local court for an offence. We have done that on one occasion. I suppose in Queensland they took a different path. When we investigate and prosecute registered health practitioners, there is a division of the New South Wales Civil and Administrative Tribunal, the Occupational Division. We have this prosecutor there. To create the same sort of process for unregistered practitioners would be more expensive to do it that way. I do not have a strong view on that. I suppose in terms of consistency of procedure, registered practitioners have that opportunity to appear before a tribunal and argue their case in public. Our proceedings are in private and they are just done by us and we can make the order and then prosecute them for a breach of order. It is a different procedure. The current procedure is less expensive and less formal.

Mrs ROZA SAGE: Is there any benefit in leaving it as is, as opposed to going further?

Mr PEHM: The only benefit I can see is that those hearings would be held in public. You talk about public warnings and public registers, and you put them on the Internet and no-one publishes them, who knows. If there is a case before an open tribunal it may attract more publicity. It would be more expensive. If there is an advantage, it would be that.

CHAIR: There being no further questions, thank you very much for your evidence 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 PEHM: Yes, no problem.

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

Mr PEHM: Thank you for the opportunity.

(The witness withdrew)

(The Committee adjourned at 12.44 p.m.)