NURSES AMENDMENT BILL 2002

Second Reading

Resumed from 27 November.

MR R.C. KUCERA (Yokine - Minister for Health) [4.21 pm]: I refer to a number of issues raised in the House by various speakers last week. I will start with the comments by the member for Murdoch. I thank him for the position he has taken on this matter and for his constructive comments on the development of the Bill. This legislation will make a significant change to the profession of nursing, as was pointed out by him. Ultimately, the Bill will symbolise the eventual professionalisation of the vocation of nursing. I said that to a group of nurses the other day, to which they replied, "Yes, you are right; it is not a vocation any more, it is a profession." They are quite correct. As nursing education programs for the delivery of health services generally move forward and climb up the ladder more and more, there is no doubt that those programs will deliver health services in a different way. There is no doubt at all that the delivery of health services generally has changed. We have just debated the way in which health services are delivered. However, the Bill we are debating is a different kettle of fish. It is now acknowledged across the world that the delivery of health services generally must change, whether it be in this country, in the United States, in the United Kingdom or anywhere. More and more, the role of nursing, the delivery of medicine and the delivery of care are changing.

A lot of debate has taken place about the academic versus work-based training of nurses. We are much too far down the professionalisation pathway to consider a move back. However, there is very much a capacity to train nurses in the medical system to ensure that they are exposed to their workplace a little earlier than they are currently; that has been taken care of by this legislation. The role of nursing generally is changing and becoming far more sophisticated, with a greater expectation on nurses for the delivery of services.

The member for Murdoch referred to the number of nurses. This year, as a result of the Nurse-Link programs and training programs, some 1 600 nurses applied for places in tertiary education institutions. Despite all the talk of a crisis, we have no problem attracting young men and women to the profession of nursing.

This Bill will provide a career path to nurses generally. Nursing is now becoming very much a first career option. As I said in the previous debate, the philosophy of health care in the past eight to 10 years has brought us to where we are now with a shortage of nurses in our system and generally across the world. About 10 years ago there was a move to day-surgery delivery and it was decided there would be no need for the number of nurses that we now have in the system. The reality is that we got it dreadfully wrong. Coupling that with a shortage of professionals generally, including doctors and allied health professionals, indicates the real need for and urgency of this legislation.

I caution all members in this place on their terminology when they refer to this legislation. This Bill has absolutely nothing to do with a shortage of doctors; it has everything to do with excellence in nursing and with acknowledging and, in fact, honouring the nursing profession. It is about lifting the level of nursing so that nurses are properly recognised for what they do, for the work they carry out and, more importantly, for the work they will be trained to carry out. The support that the member for Ningaloo gave to this legislation was commendable. He, as much as anybody who works in remote areas, knows of the desperate need for nurses. However, I must re-emphasise that this legislation is not about a shortage of doctors.

Comments were made recently by the Australian Medical Association about a shortage of doctors. The AMA appears to be the only organisation at this stage opposing this new legislation. As the member for Murdoch said, it was a pretty half-hearted opposition. I was very disappointed, when I received final submissions on the legislation, that the AMA did not even bother to make a submission. On 20 August this year we gave the AMA a copy of the legislation and asked it for further comment; we received no submission from it. We spoke with the AMA again on 13 October and invited it to a briefing, but it did not attend that briefing. That is a shame because this must be a collaborative effort. Finally, on 7 November, the AMA asked for another copy of the Bill because its head adviser had lost the copy we gave it. I do not believe, therefore, that the AMA had a great deal of issue with the legislation.

I will move on because members in the House have indicated fairly broad-based support for this legislation. I also note that the member for Murdoch referred in his remarks to the need for a total rethink by the Commonwealth on the delivery of health services generally. Reality must be applied to the delivery of those services. In saying that, the member for Murdoch referred to the provision of Medicare numbers to nurses, which is not proposed in this legislation.

Mr M.F. Board: I was not suggesting that.

Mr R.C. KUCERA: No, but that was the context in which the matter was raised, as I understand from *Hansard*. I am not saying that he suggested that but that is the context in which we are talking as we progress the matter.

There is no provision in this legislation for Medicare numbers to be granted to nurses, nor can there be because that is a decision for the Commonwealth. If in future the role of nurse practitioners evolves right across Australia, the Commonwealth may very well refer to it.

As I said, the public does not regard ownership of this issue as a problem. The whole issue of nurse legislation generally has been broadened as we have gone through the consultative process. When I became minister some 21 months ago, this was one of the first Bills considered by the Government. It was made clear to me by everybody involved with it, in particular the Nurses Board of WA, that the matter was urgent. I congratulate the board on its involvement in the matter. The member for Murdoch said that the legislation took some time to come before the House today. However, when it was first considered it referred only to remote area nursing. It was obvious from the Health Administrative Review Committee report that there was a need to broaden the role of nursing generally across this State. That being the case, we changed the scope of the legislation to include what we have called designated areas; and during consideration in detail I will explain how that system will work.

To answer a question from the member for Ningaloo, when the legislation is first introduced there will be a transitional period. That will allow the 32 nurses who currently work in remote community areas to apply to become nurse practitioners provided they meet the criteria. In most instances they will not be required to go back through the initial examination process; there will be a brief examination process and a recognition of their current competencies and levels of operation. There will be some 60 graduates, as was mentioned by the member for Murdoch, provided we get 20 applicants a year over the next three years.

The member for Murdoch referred to the issues that arose in New South Wales. The introduction of the legislation in New South Wales was very different from the legislation in this State, because it was not based on collaboration between the health service and the nurse practitioners, and there was a great deal of resistance from the medical practitioners. That will not occur with this legislation, because it was a collaborative effort between the health services. There will also be designated areas, and we will put in place clear protocols for the practice of nursing in those designated areas.

The reason that it took us a little longer to bring this legislation into the House is that once we had broadened the scope of the legislation, it was necessary to take it back to all the major stakeholders for consultation and for the submissions to be processed. The first draft was put before me on 20 March last year. It then went out for further consultation. The process of making the necessary changes has been very speedy. Of course we would have liked to have this legislation 20 years ago when it was first introduced by Hon Lyla Elliott, a former Labor member of the upper House. However, at that time it was defeated by the coalition, because it believed it would usurp the role of doctors. Perhaps we have come a little further since that day. This legislation is really about the universal delivery of health services, not just about doctors being in short supply. The member for Murdoch talked about the support from all the stakeholders. There is strong support from the general practitioners in this State, particularly those who work in country areas. The Royal Australian College of General Practitioners took part in the consultation, and I am pleased that it gave its support for this legislation.

The member for Murdoch made a comment about geographic and designated specific titles. It is true that this legislation will allow a nurse to seek the qualification of nurse practitioner. However, a nurse can practise as a nurse practitioner only if he or she is working in a designated area. There are a number of reasons for that. The legislation will not allow a nurse practitioner to hang up his or her shingle and operate autonomously and independently within the health system outside of a recognised and designated health service. This legislation will apply equally to the private health system. I suspect that in the private system there will be some difficulties with payment, because the private system gets much of its funding from the Medicare system, whereas the public hospital system does not and will simply support the nurse practitioners within it. Be that as it may, the private system will also be entitled to apply for nurse practitioners, and we will be encouraging it to do that, particularly in the aged care sector, because this will be a real boon for that sector.

The situation with nurse practitioners will be like the situation everywhere else in the work force these days. The fact that a person is qualified as an accountant does not mean that he will be able to get a job as an accountant. That is one of the downsides of this legislation. The Leader of the National Party talked about the designations and said that he would like to talk about that further during consideration in detail, which I am happy to do. The upside of this legislation is that if a designation is available in a particular country area, it will encourage people to seek that designation and stay in that area. That will be a great opportunity to stabilise the country work force.

One of the problems with doctors is that unfortunately I can drive along Stirling Highway between the University of Western Australia and Fremantle and I will find more doctors in that stretch of highway than I will find in the entire wheatbelt. I suspect the reason is that there is no geographic distribution of doctors in this

country. However, that is for the federal Government, not me, to decide, and I raised that issue with the federal Minister for Health and Ageing just last Friday during the negotiations on the Australian Health Care Agreements. I do not think we should repeat that problem with nurse practitioners, particularly in country areas. However, I think there will be plenty of jobs for nurse practitioners, because people will recognise the value of what they do. Many people may be qualified as directors of nursing in this State, but at the end of the day only a certain number of jobs are available for directors of nursing. The qualification of nurse practitioner will not be an automatic qualification. It will be the capacity to carry out a role. That is very different from simply getting a qualification. This Bill will link together the qualification and the capacity to carry out the role. That is very different from simply saying that this will be another level of nursing. It will not be another level of nursing. It will be a qualification and a capacity to carry out a role.

Many members have spoken about the kinds of things that nurse practitioners will be able to do. There is no doubt that there will be an evolution as we go along. Each designated area will be required to establish a business case as to why a nurse practitioner should operate in its area. The business case will include funding issues. The member for Avon said that we will need to put up new money. The reality is that these moneys are already factored into the health budget as a need. In many areas our wages budgets are not being fully utilised or are being eaten up by agency nurses, as has been mentioned on a number of occasions. However, if a need does arise for a particular health service to acquire new money for the employment of nurse practitioners, obviously that will be part of its business case and it will be part of the budgetary process. There is no suggestion at this stage that it will be anything other than that. In many instances, particularly remote area nursing, the money is already there. The proposal for designated areas will be presented to the chief nurse, or the principal nursing adviser as he is currently - the acting chief nurse - who will advise the director general.

I thank the member for Alfred Cove for assisting with an amendment on that matter to ensure that the chief nurse will have input into the process of developing designated areas and will give advice to the director general. Once an area has been declared a designated area, it will be required to submit and develop a series of protocols that will dictate the practice for the nurse practitioner within that system and the collaborative efforts that will need to exist within that system. In other words, the nurse will be required to have a qualification as a nurse practitioner in order to work in a designated area. Over-pinning that will be a series of protocols or practice guidelines that will apply to that designated area so that the nurse will know what he or she will be doing in that area. The member for Ningaloo commented on problems that he perceived in some of the smaller areas, in which, as he put it, the boss dictates what the nurse will do in that area.

Mr R.N. Sweetman: Yes - the senior medical officers and the health service dictate how they can practise.

Mr R.C. KUCERA: This legislation will remove that, because a series of agreed guidelines, protocols and practices will be put in place for each designated area so that the nurses will know exactly what they are allowed to do. More importantly, the nurse practitioner's colleagues also will know what they are permitted to do and what their level of responsibility is. That will be clearly designated by the Nurses Board of WA and the Director General of the Department of Health as they develop those protocols.

Mr R.N. Sweetman: That is also in the event that the area is designated in the first instance, because, from what I understand from the legislation, none of the areas in my patch will automatically be designated from day one.

Mr R.C. KUCERA: None of them will be automatically designated.

Mr R.N. Sweetman: There is none in this State.

Mr R.C. KUCERA: We have recognised at this stage that about 32 areas can very quickly put together a business case. They will still have to go through the protocol of putting forward a business case. If their business case is accepted by the Nurses Board, the chief nurse and the director general - I can go into it in a little more detail if the member wishes - the business case will then state that the designated area can employ a nurse practitioner. Secondly, if a nurse who is already working in the area has the required competencies to become a nurse practitioner, a transitional process in the first six months of the legislation will allow that to occur.

Let us say that a nurse works in a nursing post at Shark Bay, it is considered a designated area, the business case supports it and the nurse has the competencies. She - I keep saying "she" because about 97 per cent of our nurses are young women - can apply for the role. If the nurse is accepted, the designated area will overlap. It sounds a little complicated but it is not; the way it pans out is quite simple. That is the way it will operate. While the nurse is working in that designated area, she will carry the title of nurse practitioner. Should the nurse move out of that area and not work in a designated area, she will revert back to the normal title of registered nurse but will carry the qualification of nurse practitioner.

Mr R.N. Sweetman: For three years.

Mr R.C. KUCERA: Yes, for three years. If the nurse continues to practise, she will not have to re-register because that qualification is continual. Only if the nurse moves out of the area will she have to re-register.

Mr R.N. Sweetman: That is, practise as a nurse practitioner.

Mr R.C. KUCERA: Yes; nurses will not have to re-register because they will continue in their role. However, if they move out of the area, as the member rightly asked during his speech, there is a requirement for them to re-register every three years. That is different from the normal registered nurse registration. The reason for that is that they have far higher responsibilities as nurse practitioners. They also have prescribing rights and have the rights to administer schedule 4 and schedule 8 drugs, which rights are constantly changing. It was considered by the Nurses Board and by most stakeholders that there should be an added requirement on nurses to make sure their practices are current, similar to the requirement for doctors. It was considered that three years was a proper and appropriate time in which that could occur. As I have said, this legislation is evolutionary. No doubt, if it needs to be extended down the track, it will be. I suggest to the member that that is simply a way of ensuring that the added responsibility and the additional role are adequately supervised. I think they were the only issues raised by the member for Ningaloo.

Mr R.N. Sweetman: The other issue was whether nurses who are practising in these nursing posts now can somehow be assessed and registered as nurse practitioners instead of doing the 12-month postgraduate course.

Mr R.C. KUCERA: Yes; that is part of the transitional process. I do not have the details in front of me now, but I can give the member that information during the consideration in detail stage. As I understand it, the nurses who do not have the competencies and who are not qualified will then go through the full 12-month course. However, I will verify that with my advisers later.

The member for Alfred Cove raised a couple of issues, including the code of practice and the designated areas. I think I have covered those issues pretty well. The code of practice for nurses is the generic code of practice. The code of practice will be decided by the Nurses Board, in consultation with the chief nurse, and that will be agreed upon. It is a generic code of practice that is included in the training programs. It will be presumed that when each nurse practitioner passes or qualifies, that nurse is generically qualified under the code of practice. As I said before, there are a series of protocols that make up the reason for a particular area being a designated area. Within that set of protocols will be the scope of work or scope of practice that the nurses can carry out.

The two overlapping issues are the generic code of practice, which is decided by the Nurses Board in consultation, and the protocols that underpin that in the area in which the nurse is operating. For instance, the generic practice for somebody working in an emergency department and the generic practice for somebody working in a remote community in the north west will be the same. There are certain levels of competencies that we will expect a nurse to have, but the protocols for operation within the designated area will be very different. Somebody who works in Halls Creek will have very different needs from somebody who works in a major emergency department in the city. Those are the two overlapping issues that the member raised in her speech. I repeat: those protocols will be included in the business case so that everybody knows what the role of the nurse is, including the clinicians within the hospital system where the nurse is working.

Another point raised by the member was about leaving the opponents to block out the nurse practitioners. That is an issue with any legislation, but in this case there is flexibility for us to work around those kinds of issues. However, it is very much a collaborative piece of legislation that will rely on designing the protocols within the area before the nurse goes to work there. It was the other way around in New South Wales. Nothing was designed. Nurses went to work as nurse practitioners and then there was opposition from clinicians. In fact, New South Wales is now changing its code of practice and its generic requirements. It is looking towards changing its legislation to fit the model we are now applying in Western Australia. In that case we are taking somewhat of a lead. A lot of this is based on what comes out of Ireland and England. One of our advisers is from Ireland and has been working to assist us in the establishment of this program. There is also flexibility in the Medical Act, and some of the amendments apply to the Act to allow that flexibility. I believe the flexibility will exist in this system much differently from the way it exists in New South Wales.

I also thank the member for her assistance with the amendment. I agree that there needs to be a very strong input not only by way of advice but also in recommendations from the chief nurse. In answer to one of the member's queries, the position of chief nurse in this State currently is with the public sector management group. I understand that the position will be advertised before Christmas this year. In fact, I am a bit disappointed that it has not been done a little more quickly. However, part of that has been due to the hard work that has been done by the people who put the job description together. When this legislation is passed, and until the position is finalised, the current acting principal nursing adviser, by virtue of his current office, will be the person who advises the Director General of the Department of Health.

The member for Darling Range also raised a number of issues, and I thank him for his input on this legislation. He kicked it off. It was as a result of some of the hard work he did that this came before me and allowed us to extend the scope. I put on the record my appreciation for the hard work he did when he was the minister. There was formal consultation and in 1998 the history of this legislation was discussed and also the position some 20 years ago, when Lyla Elliott first introduced this legislation into the Parliament. The difference is that we have broadened the scope to include designated areas. As I have explained, we had to have further consultation.

I reiterate that this is not about replacing doctors; it is about enhancing and recognising the nursing profession. We cannot and will not go back to what people often think of as the good old days, as nursing has now moved into the technological age and needs to be totally supported by a university education. At the end of the day the fundamental principle and practice of nursing does not change - it is always the same - and that is the giving of care. As the protocols and generic practices are developed, and as this legislation takes hold in the medical and health communities, it will reflect that.

Delivery of health has changed and, in time, we will see that the delivery of health by doctors has also changed. In fact, there is a need for that. The member for Murdoch stated that the delivery of health has broadened and it must move into the twenty-first century. There is a greater need for the various sectors of the health system to work together. Over the past 12 months it has been pleasing to see that almost all of the major sectors in the health service are now talking constructively to the Government.

The member for Avon raised a number of issues, the main one of which was funding. Funding is built into and is taken into account in this legislation. It is a minor issue at this stage, because it will be part of the business case that designated areas will have to support. Some $300 million-plus is contained in the development package for nurses. Country budgets have also been very well managed this year. The level of usage of agency nurses has dropped dramatically, particularly in the goldfields. It is a pity that the member for Kalgoorlie is not here.

I do not see nurses carrying the load of doctors. I see nurse practitioners carrying out the role of nurse practitioners; that is, doing the work that it is agreed that they can do, carrying out and delivering health services within their designated areas in accordance with the agreed protocols.

The member for Avon made a very good point about telehealth. Last Friday I raised the issue of telehealth with the federal minister and it will form part of the reform program that we have suggested should be included in the Australian Health Care Agreements this year, together with the issues we debated earlier for general practitioners etc. There is a strong role for nurse practitioners in telehealth. The member for Alfred Cove raised the issue of payment for those services. I am not suggesting that I have any power in this area, but, in a bipartisan way, we may be able to take that issue to the federal Government in due course. However, this legislation does not deal with it.

The other matter that the member for Avon touched on was the training of nurses in the Northern Territory. I discovered this situation last year when I went to the Geraldton Regional Hospital. I immediately asked our educators why that money was going to the Northern Territory and why we were not doing this in Western Australia. I received an immediate answer, and I am happy to say that that practice has ceased. Nurses can still apply to the Northern Territory, but these programs have now been put in place. In fact, the first of some 80 enrolled nurses graduated from a transitional program at Curtin University of Technology. Twenty-six nurses participated in that course and almost all of them were from country areas and had gone through a transitional program similar to that conducted in the Northern Territory. The great part about that program is that it identifies nurses within the system who live in a particular town, it allows them to train there and, more importantly, they stay there. We want to develop a core work force in every country town and we want them to be part of the system.

It is my view that all of that training should be done in this State - we do not need to use other universities - and with the amount of money we have put into refresher and retraining courses following our recent recruitment program, I do not know why nurses would want to go outside the system to be retrained. Our system fully supports them with scholarships and provides them with a workplace and a wage whilst they are doing the course. The funding of rural nurses will be supported. As I have indicated, 32 will go through a transition process, and country areas will see the introduction of nurse practitioners long before we see them in the city. If this legislation goes through speedily, I hope we will see the first of the nurse practitioners in country areas as early as April or May next year, provided those nurses can satisfy the processes that are in place and provided the chief nurse can push them through the courses that are now available. Funding is not an issue, and it should not be made an issue; it is built into the budget and it will be honoured.

You, Mr Acting Speaker (Mr P.W. Andrews), raised a number of issues, most of which I have dealt with. You touched on the opposition from the doctors. The role of nurse practitioners will be specified in the protocols and will actually support doctors. Although this State has a shortage of 600-odd doctors, it cannot be argued that we

do not need nurse practitioners. I stress that this is about first-class nursing; it is not about issues raised by the Australian Medical Association such as second-class doctoring - it is far from that. This legislation is not about a shortage of general practitioners. You, Mr Acting Speaker, raised the excellent analogy of the designation of a principal in a school. We would all like to be the principal, we would all like to be the director of nursing, but there are times when there are not enough jobs to go around, although, provided we have the classification of nurse practitioner, there is no barrier. You also talked about sports medicine and triage.

The nurse practitioner is ideally suited to that situation. During a recent visit to Ireland and England we saw that the triage nurses in all the major hospitals were nurse practitioners or were in the process of becoming nurse practitioners. We met the first nurse practitioners when we were in Ireland. Those positions were specifically designed so that the nurse practitioners would work in the emergency areas and take the pressure off their colleagues. With the downturn in bulk-billing in this State, with more and more people coming into the emergency departments when they should be going to a family doctor, the nurse practitioner is ideally positioned to deal with many, not all, of those cases. They will not be diagnosing serious illnesses. Their role is to recognise a need and to deal with that need within the protocols that are designed for them and within their code of practice. You also referred to satellite dialysis, Mr Acting Speaker. There is a need for dialysis nurses and this process will suit them well; however, it does not take away the need for physicians in that area.

The member for Ballajura talked about prescribing, and I think there was some misunderstanding about his comments and the role of nurses. Nurse practitioners will not be permitted to prescribe schedule 8 drugs, but they will be able to initiate and administer them in an emergency setting. They cannot write out a script and let a person take a box of schedule 8 drugs home. Many of the schedule 4 drugs are simple pain-killers that patients can get from a pharmacy anyway. The protocols and codes of practice will reflect what the nurses can do in those circumstances. There is no suggestion in this legislation that they will be prescribing schedule 8 drugs.

The member for Murray-Wellington referred to the change in health demands and services. I agree with him totally. I also agree with the comments he made about doctors. This legislation is not about doctors. He made a comment that perhaps there was a fear about doctors' wages. I will not comment on that. Any thinking doctor within the system will work cooperatively with nurse practitioners to take some of the pressure off. I know that doctors working in general practice in the country and the suburbs see this as a real means of relief; they know that they will be able to perhaps have a Saturday night off and somebody competent will be there to deal with things in the first instance. This is about cooperation.

In summary, this legislation has been some 20 years coming. As the Minister for Health, I am proud to have introduced it. Despite some comments made this afternoon by people in the nursing profession who are in the public gallery, the Bill is about valuing nurses and making sure that they are recognised for what they do. It is about recognising that nursing is a profession that needs to be supported and recognised in its own right in the medical and health systems. The Bill is a significant piece of legislation for those people who have been practising in the health service for many years. I am pleased to have introduced it into the House, and I commend it to the House.

Question put and passed.

Bill read a second time.

Consideration in Detail

Clause 1: Short title -

Mr M.F. BOARD: Clause 1 provides for the Bill to be cited as the Nurses Amendment Act 2002. It opens up the opportunity for the minister to explain the purpose of the legislation. As the minister clearly indicated in his second reading speech, and as the Opposition has indicated, we support the legislation. As I indicated in previous debate, this Bill is the first of a number of pieces of legislation that we hope will come before this Parliament. The Bill amends the Nurses Act 1992, which is dealt with under clause 3. Was the minister looking at other amendments to the Nurses Act that might be dealt with at this time? We are dealing specifically with nurse practitioner legislation. However, as we are addressing the Nurses Act, a number of other issues could be brought in at this time. The Australian Nursing Federation and other groups involved in community debate have raised the question of other possible amendments to the Nurses Act. While discussing the name of the proposed Act, the minister might like to take the opportunity to indicate whether we are likely to see any further amendments to the Nurses Act in this Parliament; and, if so, when they might be introduced and what they might be. I know it is a wide-ranging question, but it may preclude our debating clause 3.

Mr R.C. KUCERA: I understand that under the national competition policy it is intended to have further amendments to the Nurses Act by requirement, because it is a requirement under federal legislation, by June 2003. The Bill is specifically aimed at dealing with the issues raised in the second reading speech. Further

amendments under the national competition policy may be introduced later on. They will need to be before this House or at least under way by June 2003.

Mr M.F. BOARD: If I may be allowed some licence, the reason I raised the question is that I understand that under the national competition policy and in accord with other States, amendments would be introduced for aligning legislation. Has the Department of Health or the minister any intention of revisiting the Nurses Act because of issues that may need to be initiated by the State? I refer to the training of nurses and the employment of student nurses, which matters have been raised in this House, and a raft of other suggestions about career structure and other issues that could be addressed through amendment of the Nurses Act.

Mr R.C. KUCERA: The member is right when he talks about alignment, but this Bill deals with a specific need. A comprehensive review relating to national competition policy will take place down the track. If there is a need to raise the issues that the member has introduced, we will look at those issues then.

Clause put and passed.

Clauses 2 and 3 put and passed.

Clause 4: Section 4 amended -

Mr M.F. BOARD: Clause 4 is significant in that it amends section 4 of the Act to include definitions of "designated area" and "nurse practitioner". May I take the opportunity of thanking the minister's staff and those responsible for taking up the suggestion of having the mark up of amended sections of different Acts? It is an excellent way of doing things. I suggest that all ministers look at how that might be done in future. It is advantageous to not only the minister and his staff but also the Opposition and other bodies that want to follow what might be slightly complicated legislation when it is amending a whole range of Acts simultaneously.

We need to spend some time on this clause, because, as do some other clauses, it goes to the heart of what we are endeavouring to do. We need to make sure that the minister explains during consideration in detail exactly what is taking place with a designated area. Under this clause a designated area means an area designated by the Commissioner of Health under section 23(2)(e) of the Poisons Act 1964. A designated area is generally considered to be an area of need, but there do not seem to be any guidelines on how that designated area will be determined and what consultation is required before it is determined. What process must be considered before an area can be designated an area of need? What additional criteria must be considered?

Dr J.M. WOOLLARD: This is the contentious aspect of the Bill. During the second reading debate I suggested that "designated area" could include, for example, coronary care nurse practitioners and intensive care nurse practitioners. In that case, individual hospitals would not be required to complete a business plan. I suggest that the minister identify not only coronary care or aged care as designated areas for nurse practitioners, but also an entire hospital. However, the clinical protocols attached to that designated area might exclude the nurse practitioners within the public hospital from administering medication in a speciality area. Nonetheless, the designated nurse practitioner could practise within 80 to 90 per cent of the hospital setting. I will be very interested in the minister's interpretation of "designated area".

The minister's adviser indicated that to accommodate the Poisons Act, new subsection (2)(e) had to be added to section 23 of the Poisons Act. If this Bill is reviewed after it becomes an Act, can subsection (2)(c) be modified to read "any dentist or nurse practitioner is authorised"? Proposed subsection (2)(e) was probably unnecessary; it could have been covered in subsection (2)(c).

Mr R.C. KUCERA: As part of the project a framework is in place for the implementation of nurse practitioners in Western Australia, which sets out the guidelines for developing a business case for the designated areas. The member for Alfred Cove was referring to designation of speciality areas; whereas this clause designates a workplace, which is very different. If Royal Perth Hospital wanted acute-care nurses or coronary-care nurses practising across a designated area, that would be built into its business case. The clause provides for a workplace not a speciality. The nurses will be nurse practitioners operating within designated areas. We should not confuse the speciality with the actual area.

The designation will protect individual nurse practitioners because it will ensure that the necessary resources are provided by the employer, including access to diagnostic equipment, information technology and all other equipment. Clinical protocols that form part of the designation, which are designed as part of the business case, will provide guidance on how and where nurses will operate within designated areas. I am not sure whether that answers the member for Alfred Cove's question.

The specific issue the member raised about the Poisons Act refers to a further clause. At this stage there is no intention to amend section 23(2)(c). It would allow nurse practitioners to prescribe and that is not desired

generally at this stage. The Bill must provide that a nurse practitioner will prescribe within the protocols attached to the designated area.

Mr M.F. BOARD: We must explore this area. If we can resolve this now, it will save us time down the track. The issue about the number of nurse practitioners the State will have is critical. The Opposition indicated during the second reading debate that the number is not defined. The minister indicated that 20 scholarships a year would be offered at Curtin University over three years, which totals 60. On the other hand, he indicated that about 30 -

Mr R.C. Kucera: The number is 32.

Mr M.F. BOARD: Yes; nurse practitioners could be appointed to 32 designated areas based on their experience without undertaking any additional study. In that case would the number increase to 92 nurse practitioners? Will the number then be limited to 92?

Mr R.C. Kucera: We are not limiting the number in any way. At this stage we will fund 20 scholarships a year. If more people apply, we will reconsider the issue. More places might be required than we are suggesting at this stage. Western Australia is a big State and many areas would be suitable for nurse practitioners to work in.

Mr M.F. BOARD: People are concerned about this issue. As the minister indicated, this is not about a personal qualification although a nurse practitioner must be qualified. However, nurses cannot be nurse practitioners unless they hold a position. Under this scenario, one could end up with 500 positions. As a result of the legislation, by stealth, every nurse practitioner who qualifies could end up in a designated area of some kind because the criteria for "designated area" are not defined. That matter needs a fair amount of clarification.

Mr R.C. KUCERA: The difficulty is that the member is confusing designation with registration. One could end up with 500 nurses qualified to be nurse practitioners, but only 30 such jobs may be available. Many senior nurses are qualified to be senior management nurses or directors of nursing. Many junior nurses are qualified to work at higher levels. The difference between this designation and qualification is that although a level 2 or 3 nurse automatically moves to a higher level when the requisite qualifications are achieved, a nurse would not attain a nurse practitioner position unless one was available. To use an analogy from my old life: at the age of 30, I was qualified to be a commissioner of police. I had little chance of being a commissioner at 30 until a job became available. We are certainly encouraging nurses to seek recognition of their qualifications, but a job will not necessarily be available unless they wish to work in a designated area.

As I mentioned briefly when referring to an issue raised by the member for Avon, this legislation is a means of stabilising some of the senior positions in the system across the State. If everybody automatically by qualification were given a job as a nurse practitioner, it would not be appropriate. In that case, I would agree with the member. However, the Government has tried to strike a balance between the requirements of the system and the number of nurses with the competencies to rise to this level of qualification.

Mr M.F. BOARD: I am clear on this matter; it is not confusing. I clearly understand the difference between registration as a nurse practitioner and holding a position as a nurse practitioner in a designated area. The designation for these areas is currently uncontrolled; namely, it is at the discretion of the Commissioner of Health. Therefore, nothing says that the State cannot have 500 designated areas. The Opposition today has had some representation from the Australian Medical Association, which wants some amendment made to this legislation. I indicated in my contribution to the second reading debate that the Opposition would not move to amend the Bill. However, the door was left open, depending upon how consideration in detail progressed, and an amendment may be made in the upper House on the "designated areas" matter.

For clarification in *Hansard*, the commissioner could easily decide under the proposed legislation, as a result of pressures applied in the public health system, to fill as many nurse practitioner positions as possible where a shortage of GPs exists. This may be in after-hours areas, secondary hospitals, aged care, triage or in emergency departments. Nurse practitioners may be appointed to designated areas of need to alleviate the pressures caused by a current under-supply of GPs. I share the argument put by the AMA, although not the AMA's level of concern. I believe our public system ultimately will be well served. The concern is that this measure could easily remove the emphasis on incentive programs to attract GPs to certain areas. By the minister's admission in his second reading speech, this measure is not about replacing doctors but about ensuring that all areas have access to GPs and a first-class health system. It is about substitution in remote and rural areas where it is not possible to attract GPs because of numbers and isolation. I have supported extension to other areas, but some rationale must apply for the appointment of designated areas and how they are to be fixed. A shortage of GPs is not a sufficient criterion on its own for this change. I can understand the AMA's concerns about that position. I raise those points because of those concerns, not through any lack of understanding about registration and practice. I refer to the possibility of the Commissioner of Health designating as many areas as he thinks are

required, and moving nurse practitioners into areas for which GPs feel incentives should be provided by the federal and State Governments to attract GPs to provide the primary health care.

Dr J.M. WOOLLARD: I am disappointed to hear the comments of the member for Murdoch. I am suspicious, as the Acting Speaker (Ms K. Hodson-Thomas) would know, about the Government's position in introducing this Bill. The minister said today that it is to fulfil a need in remote and rural areas where there is a shortage of medical personnel. I was disappointed to hear the minister state that nurses will not prescribe, but will only follow protocols.

Mr R.C. Kucera: That's not correct. I didn't say that.

Dr J.M. WOOLLARD: I am happy to take the correction.

Mr R.C. Kucera: They can prescribe schedule 4 and administer schedule 8 drugs.

Dr J.M. WOOLLARD: I thank the minister. That situation may need to be reviewed at a later date because serious problems will arise from the application of the Bill in remote and rural areas.

Mr R.C. Kucera: I said by way of interjection that all medical practice and legislation is evolutionary these days - that is recognised.

Dr J.M. WOOLLARD: As the minister stated, this Bill is at least 10 to 15 years late. Yes, I am still sceptical about this Bill, but I was pleased to hear the member for Murdoch speak about a bipartisan approach to improving health care delivery, and the role nurse practitioners can play in health care in various areas. I continue to be uncertain why the minister has said it is not a specialty area. I am unsure where the minister draws the line between a specialty area and a designated area. He said that coronary care could not be regarded by the Bill as a designated area; yet, he said aged care could be. When the minister introduced the Bill, he said that emergency departments were very needy areas for nurse practitioners.

I would like to explore further with the minister the difference between a specialty area and a designated area. An emergency department is a specialty area; yet, he is saying that nurse practitioners can practise as nurse practitioners only in designated areas. Will the minister tell me how he determines which area is specialty and which is designated?

Mr R.C. KUCERA: The notes on page 7 supplied by the Western Australian Nurse Practitioner Project quite clearly lay out the principles that establish the need for a nurse practitioner and the designation of an area of practice for nurse practitioners. The first and fundamental step is to identify the need for a nurse practitioner in a specific area, which must also be in an area of advanced clinical practice. To identify a need, we expect everybody associated with an area to develop the protocols that are required to move to the second stage, which is the preparation of a written application and a submission to the Director General of Health.

The current statutory requirements of the Acts referred to in the Bill refer to the Commissioner of Health but, because of the Machinery of Government Taskforce recommendations, we now have a Director General of Health, who is one and the same person. If I refer to the statutory Commissioner of Health, I am referring to the existing position of Director General of Health. The name will be changed under omnibus legislation when the machinery of government Bill comes before this House. I hope that clears up any confusion.

A written application by submission to the Director General of Health requesting an area to be designated nurse practitioner for practice and including details of area preparation, job description, funding details and the clinical protocols - all matters referred to by the members for Murdoch and Alfred Cove - will be included in the deliberations in the first instance. Involved in those deliberations will be the chief nurse and, I have no doubt, the medical director and other senior people who will comprise the implementation committee; that is referred to in step 3.

I will go back a stage. I was disappointed to hear the comments from the Australian Medical Association through the member for Murdoch. The AMA was requested on three occasions to make submissions on the legislation; it did nothing. It is a little cynical for the AMA to raise issues at this late stage when this legislation is before the House. One must wonder, as the member for Murray-Wellington said in his contribution to the second reading debate, about the AMA's motivation. In reality, the clinicians and doctors whom we will be working with will be part of the developmental process in deciding what is and what is not a designated area.

The suspicion of the member for Alfred Cove that the Government will go off willy-nilly appointing nurse practitioners to overcome a shortage of doctors is simply incorrect. There are clear guidelines under the Medical Act on what doctors can do and what other people cannot do. We have not sought to change any of those guidelines in the Medical Act, other than what is clearly stated in this legislation. We are not setting out to create by stealth a secondary class of doctors. We are setting out to acknowledge the value of nurses and to put

on record from a legislative perspective what nurses in many instances are simply doing now, and to acknowledge that under a system of education, qualification and recognition.

Finally, the approval process will result in a submission being made to the Director General of Health, and he or she advising in writing the outcome of the application. There is no system in the legislation that can be usurped. Clear recommendations will be made whether or not an application is approved. Following approval, positions for nurse practitioners may then be advertised. I am sure that if a clinician, a doctor or the AMA had an objection to that designated area after the process had concluded, they would raise it and the objection would be considered in the context in which the process was developed.

Dr J.M. WOOLLARD: Whether or not it was intentional, the minister misunderstood me. I certainly did not say that the need was to replace doctors.

Mr R.C. Kucera: I was not suggesting that. The member for Murdoch raised that issue by inference, and the comments from the AMA in latter days have confirmed that. I did not suggest you said it.

Dr J.M. WOOLLARD: I thank the minister for that, because it is certainly not the case, neither is it the reason I am giving support to this Bill.

The role of nurses has changed in the past one to two decades, as has the role of health professionals and many other allied health professionals. With the change in their role, nurses in remote and rural areas now have the education and skills to be involved in a far greater aspect of health care delivery than they were able to 10 to 20 years ago. Many general practitioners would like to have nurse practitioners, such as in the model used in the United Kingdom, working alongside them in their practice. A nurse from Ireland is working in the Department of Health. I have not worked with nurse practitioners in Ireland, but I have worked with nurse practitioners in England and I know that they play a very valuable role in the general practice setting and in other health care settings.

Mr R.C. Kucera: I understand that the Royal Australian College of General Practitioners has indicated its support for this Bill.

Dr J.M. WOOLLARD: I am not surprised at that. I have worked with many general practitioners and, in fact, at one stage worked with the College of GPs and General Practice Divisions of Western Australia Ltd. I know that many general practitioners would like to have nurse practitioners working alongside them because they believe it would enhance the care they are able to give from their general practice setting.

I take the minister back to an issue that is still a grey area for me. The minister said that nurses could not submit an application through their professional body to have coronary care recognised as a designated area because it is a specialty area. If a business case for an emergency department were presented from nurses working in the three tertiary hospitals and the application went through consultation and collaboration, would the department recognise the emergency department as a designated area? Nurses working in coronary or intensive care and aged care might submit a good business case for these areas because nurses go from one unit to another with no change in their responsibilities. My concern is that unless these areas are looked at across the board, a whole empire will be developed within the Department of Health and there will be very few nurse practitioners in the health system in the next few years.

Mr R.C. KUCERA: I will use the member's example, in which we have a group of nurses within the three tertiary emergency departments and it is suggested that that should be a designated area. They are separate health services at the moment: north, south and east. The process is that the three health services would consider that. The three health services, as the employers of those nurses, would reach agreement, and they would then reach agreement with the whole team working within that emergency area that there was a requirement for nurse practitioners within that system. This could be done within each individual hospital, or there could be a coming together of the three hospitals and they could set it up as the way it should be created. I see no barrier to that occurring, although the likelihood of that occurring is not very high. I suspect that each of the individual hospitals would designate its own emergency department as a designated area. That would still allow the nurse practitioners to move around within those designated areas. That is the first stage.

The second stage is that a set of protocols would be developed. The one advantage of the model the member is putting forward is that the protocols and the guidelines for practice would be exactly the same across all three hospitals. However, we may find that in the near future we end up with a differentiation between our emergency departments so that all heart attack cases are taken to one hospital and all neurological cases are taken to another hospital. If that were to be the case, we would still have designated areas, but the protocols within those designated areas would be different. That would mean that what the nurses would be required to do would vary from hospital to hospital. We should not forget the fact that each designated area will need to develop a set of protocols, which in turn will need to be agreed on by all the people who are working within that system.

Obviously if the clinicians felt that the role of the nurse practitioners was impinging on what they were doing, they would have something to say about it.

The reason that this model is different from the New South Wales model is that it is very much a collaborative model rather than an imposed model. Some negotiation issues will arise in the first instance as the business case is developed. However, once the business case has been developed and the protocols have been locked in, I suspect that, as we saw in the United Kingdom, this will take off. I agree with the member that the reality is that most doctors are under so much pressure in the hospital system that they will welcome anything that will take some of that pressure off them. However, I reiterate: this is not about doctors. This is about nursing and developing a set of protocols that recognises the generic qualification of a nurse practitioner and allows them to use that qualification within a designated area.

Mr M.F. BOARD: I thank the minister for putting these issues on the record. At the end of the day, though, the principles and guidelines are only principles and guidelines. They are not covered in the legislation; hence they can be changed within the Department of Health. Some people are concerned that there may be a blow-out in this area.

Let us move away from the city to the country. A country town may be trying to attract a general practitioner through some of its own initiatives and resources or through some of the commonwealth programs that are in place. As a result, the director general may decide that there may be a nurse practitioner in that area because it does not have a general practitioner. Does the minister believe that the State will then put the same emphasis on trying to attract a general practitioner to that town; and, if so, how can he ensure that? Some of the public statements that the minister has made recently about the problems in Merredin seem to indicate that if Merredin had a nurse practitioner, these problems would not have arisen.

Mr R.C. Kucera: That is not correct. I did not say that.

Mr M.F. BOARD: Obviously I had that wrong; I am happy to accept that.

What will this legislation mean for our trying to attract as many doctors as possible to the bush, trying to encourage the Commonwealth to both train and fund more doctors, and trying to find additional ways to support the education and placement of general practitioners as the first call of primary health care? This is an important issue. As the minister knows, it takes between 10 and 12 years to train a general practitioner. The situation in this State is already critical, so we will be facing a stressful period. It is important that, as we deal at the coalface with this nurse practitioner legislation, we indicate clearly what the intention is so that we get a balance. I reiterate that we support this legislation and we support the areas of need. However, we need to clarify how these areas of need will be met, because it is all very well to have guidelines and principles, but if at the end of the day the director general is under pressure, as he will be, from the minister of the day to make sure that the areas of need are being covered, he may well succumb to that pressure and declare areas as designated areas when greater emphasis should be placed on putting a doctor in place if at all possible.

Another issue is what this legislation will mean to the recruitment of overseas-trained doctors and to the provider numbers and incentives that are issued for those doctors. As the minister knows, the Commonwealth Government declares areas of unmet need and provides the funding for those areas. I believe that is done in consultation with the state minister who has to sign off on those areas of unmet need. What constitutes an area of unmet need; and will the same emphasis apply if a nurse practitioner is in place?

Mr R.C. KUCERA: A nurse practitioner will not replace a doctor. It is as simple as that. If we were to stand a ruler on end and look at the 12 inches that I am used to thinking about, two inches of that will be the role of a nurse and the other 10 inches will be the role of a doctor. A nurse practitioner cannot carry out and will not carry out the other 10 inches of the ruler. I want to make that clear.

The member referred to my comment about Merredin. The comment I made about Merredin was in the context that many of the doctors who work in country areas like Merredin need to be at the hospital or on call and available at all times - and often that is for 24 hours a day. They need someone who can legally step into the breach and be the first port of call of the triage that we are talking about. There is certainly a role for nurse practitioners there. Nowadays in virtually all country hospitals the nurse is the first person who sees a person who comes in the door. This is not about replacing doctors. If it is normally designated that a doctor will be positioned at a particular hospital, we will not replace the doctor with a nurse practitioner. However, if the capacity of the nurse practitioner is such that he or she can advise the general practitioner in that area, so be it. That will be part of the designation of nurse practitioner that will be reached. However, it would have to be reached with the agreement of the health service, because the initiator will be the health service, not the doctor. If the health service sees a need, that is how the system will work.

The member mentioned commonwealth provider numbers. There is no provision in this legislation, nor do we ask for any provision, for provider numbers. That is a matter for the federal Government. If in due course the federal Government thinks that certain things could be carried out by nurse practitioners, I am sure the Australian Medical Association will have much to say about that. I am sure the AMA will raise its concerns.

The member also spoke about the guidelines and the framework. The framework allows people to develop the protocol, which eventually must be ticked off by the Commissioner of Health. If those protocols involve a nurse practising things that are part of that 10 inches on the ruler - in other words, part of those things that he or she is not qualified to do - they will not be included in the protocol. Therefore, doctors do not have anything to worry about.

Much has been made of emergency departments. There is a role for nurses now in emergency departments, and doctors clearly recognise that. The protocols will recognise what that practice is.

Mr M.F. Board: It is not about the doctors being concerned about, as you say, their 10 inches -

Mr R.C. KUCERA: Perhaps I should change the analogy.

Mr M.F. Board: That would be good, because I do not want to talk about the two inches either. The point is that there is a concern that the current stimulus and the incentive programs for attracting doctors may go off the boil.

Mr R.C. KUCERA: That will not be the case because nurses cannot do what doctors do; nor is it the intention for that to occur. Secondly, this will be a fillip for doctors who want to go to country areas or who want to work in emergency departments. There will be additional, recognised, legislated and clearly spelt-out support for them. This Bill clearly supports their role as doctors. I would be very surprised if they did not feel supported by this legislation under those circumstances.

Dr J.M. WOOLLARD: I remind the minister that although he stated that nurses cannot do what doctors do, doctors also cannot do what nurses do.

Mr R.C. Kucera: I doubt that doctors would want to do what nurses do; it is a very hard job.

Dr J.M. WOOLLARD: In most cases a very supportive relationship exists between the medical profession and the nursing profession.

Mr R.C. Kucera: They are complementary of each other.

Dr J.M. WOOLLARD: They are complementary. The role of the general practitioner now is different from that role 20 years ago, and that is associated with the changes in medical science, research and technology. Both medical and nursing roles have evolved. That is why some of the areas regarded as traditional medical areas 20 years ago are no longer seen as part of the medical role.

I return to the issue of equity. I will address the issue of equity from two main perspectives.

Mr R.C. Kucera: I am not sure I follow you in terms of the clause.

Dr J.M. WOOLLARD: The minister said that the nursing profession could put forward a business case for an area of clinical practice, and that we now have three health services. If the health services in the northern and eastern regions put forward business cases from a grassroots level stating that they would like nurse practitioners to work within the emergency departments, and they were supported by the northern and the eastern health services, what would happen if - I am sure that this would not be the case - the nurses and perhaps the whole team working in the emergency department in one of the southern sector hospitals also wanted to appoint a nurse practitioner to that area and the health service said no? There would not be equity. I presume that, with the new title and the education some of these nurses will receive from Curtin University of Technology, there would be some financial increase in their salary. If a nurse works at one hospital and has the skills and the education to function as a nurse practitioner, but the health service has not put forward a good business case, or any business case at all, there will be no equity because there will be no nurse practitioner within the emergency department in that hospital.

I was a bit disappointed to hear the member for Murdoch's comments about overseas-trained doctors. Often overseas-trained doctors are poached from countries that are less advantaged. I do not see the nurse practitioners in this area replacing doctors. I think there is bipartisan agreement in this House that there are not enough doctors and nurses in Western Australia. Can the minister address the issue of equity in the example of a business case being put forward by one health service in an area, but not by another health service?

Mr R.C. KUCERA: It is as simple as this. The member has raised two issues, the first of which is the health service. If the management of the health service does not see the need, or does not think the business case is strong enough, for a nurse practitioner in that area, the nurse practitioner will work in the service that does see a

need for a nurse practitioner. That is how equity comes about. It is much the same with overseas-trained doctors. If they see a job in this State, they come here. That is a fact of life.

Dr J.M. Woollard: What is equity to you then?

Mr R.C. KUCERA: At this stage, equity will be what the nurses perceive. For example, if the Fremantle service does not see a need for a nurse practitioner, so be it. The business case must be supported.

I should have said this when the member for Murdoch raised the issue earlier. Under the current regulations, the designation of remote area nursing posts has worked very well. There has not been a problem. Essentially, the guidelines that we have developed mirror what has occurred in the remote area nursing posts. The commissioner has signed off on the designation of those posts.

Returning to the member for Alfred Cove's point, at the end of the day it is about the way the health service develops its business case. Many of us might think that our jobs should be upgraded, regardless of what we do. I am sure that all members, including the member for Alfred Cove, have worked in situations in which they think they do a far better job than they are being paid for. The reality is that if the boss, the health service or the team that a person works with does not see it that way, so be it. If a nurse has the qualifications of a nurse practitioner, I am sure that he or she will seek the role somewhere else.

Mr M.F. BOARD: For the benefit of the member for Alfred Cove, I advise that the Opposition supports the nurse practitioner legislation and the designation of areas in the city. However, we are trying to ensure that in no way does the enthusiasm for the designated area replace the efforts being made to ensure that general practitioners go to country areas.

Sitting suspended from 6.00 to 7.00 pm

Dr J.M. WOOLLARD: I am happy to support that nurse practitioner "means a nurse who is registered under section 22A as a nurse practitioner". However, I am not happy to support "designated area", which means "an area designated by the Commissioner of Health", because when one qualifies as an enrolled nurse one has roles and responsibilities that go with the title of enrolled nurse. If one employs an enrolled nurse, one knows what the enrolled nurse will bring to that position. When one employs a registered nurse, one knows the education, skills, values and attitudes that encompass the educational program of that person. With the new role of nurse practitioner there will be a specialised program at Curtin University. The outcome of that program means that nurses who complete that course will have to meet criteria set down by the Nurses Board of WA to be registered as nurse practitioners. The registration of a nurse practitioner should enable him or her to move between places. I return again to the issue of equity because the minister and I obviously have a very different understanding of the word. To me, equity means evenness. The way the minister is planning to implement this Bill by specifying designated areas does not allow for equity within health care services. I question the minister's definition of equity and his support for this role. I know there is support within the department. This Bill has been a long time coming. I am concerned that if the Bill goes through with lines 12 to 14 at page 3, which is the definition of designated area, the remote and rural sectors will have individual designated stations. We will have nurse practitioners in remote and rural areas, but my concern is that the support the minister has voiced in this House for nurses undertaking the role of nurse practitioner in emergency departments, aged care and other specialty areas - where such nurses could be a real asset in health care delivery - will be blocked by the definition of designated area.

Mr R.C. KUCERA: I am sorry, I do not agree with the member. There are many tasks and jobs that one is qualified for in this life, where it is to be a nurse practitioner, an accountant, or even a politician. If a person does not get preselection he does not get a seat and he does not work as a politician.

Dr J.M. Woollard: Unless one is an Independent!

Mr R.C. KUCERA: Yes, unless one is an Independent. It is as simple as that. "Designated area" simply means that a job is available for a nurse practitioner. A person cannot apply for a job unless he carries the classification and qualification of nurse practitioner. It is as simple as that. If we look at it the other way, a person can qualify as a nurse practitioner but he cannot work as a nurse practitioner unless a job is available and the job is in a designated area. If the member goes to the guidelines in the framework, she will find that her concerns about designated areas are clearly explained. If there is an agreed set of protocols in a particular clinical practice area or in a particular geographic area that includes a kind of clinical practice that is agreed upon, there is a designated area. That is the job and that is the qualification. Marry the two and one has a nurse practitioner who is working in a designated area. I do not think I can make it any clearer than that.

Clause put and a division taken with the following result -

Ayes (39)

Mr R.A. Ainsworth	Mr J.P.D. Edwards	Mr R.C. Kucera	Mr P.D. Omodei
Mr P.W. Andrews	Dr J.M. Edwards	Mr F.M. Logan	Mr P.G. Pendal
Mr C.J. Barnett	Dr G.I. Gallop	Ms A.J. MacTiernan	Mr J.R. Quigley
Mr D.F. Barron-Sullivan	Mrs D.J. Guise	Mr J.A. McGinty	Mr E.S. Ripper
Mr M.J. Birney	Mr S.R. Hill	Mr M. McGowan	Mrs M.H. Roberts
Mr M.F. Board	Ms K. Hodson-Thomas	Ms S.M. McHale	Mr R.N. Sweetman
Mr J.J.M. Bowler	Mr M.G. House	Mr A.D. McRae	Mr T.K. Waldron
Mr J.L. Bradshaw	Mr J.N. Hyde	Mr N.R. Marlborough	Mr P.B. Watson
Mr A.J. Carpenter	Mr R.F. Johnson	Mr A.D. Marshall	Ms M.M. Quirk *(Teller)*
Mr J.H.D. Day	Mr J.C. Kobelke	Mrs C.A. Martin	

Noes (1)

Dr J.M. Woollard *(Teller)*

Pairs

Mr M.P. Whitely	Mr B.J. Grylls
Mr C.M. Brown	Mr M.W. Trenorden

Clause thus passed.

Clause 5: Section 9 amended -

Mr M.F. BOARD: It is disappointing that we had to divide on the important clause 4. We have indicated that the upper House might consider an amendment to that clause, but the reality is that we support the fact that there will be designated areas. That is important. It is interesting that we divided over a clause that has universal support in Western Australia.

Clause 5 amends section 9 of the Nurses Act and relates to the issue of codes of practice for nurse practitioners. The Nurses Board of Western Australia has the power to issue codes of practice for nurses and specialist nurses. According to this proposed section, the Nurses Board will be able to issue a code of practice for nurse practitioners only through recommendation to the Commissioner of Health. Why will that be the case? Why has the Government decided to give the power to prescribe the codes of practice for nurse practitioners to the Commissioner of Health rather than leave it with the Nurses Board? The Nurses Board already has the power under legislation to deal with codes of practice. It would be consistent to give that body the power to issue codes of practice for nurse practitioners. If my reading of this proposed section is correct, that power will be given to the Commissioner of Health. I thought that the Nurses Board would have been entitled to issue the codes of practice, as it is now. The new regime will provide nurses with accreditation options. It is part of a wider opportunity for them to progress. Hence, this legislation should be governed by the Nurses Board and not necessarily by the Commissioner of Health. I ask the minister to clearly explain why that power, particularly as it relates to nurse practitioners, is being moved from the Nurses Board to the Commissioner of Health.

Mr R.C. KUCERA: I thank the member for Murdoch. I had the same question when I first read the clause. The answer is that it closes the circle. It will ensure that both the Commissioner of Health and the Nurses Board are quite clear about what is a code of practice for nurse practitioners. It will also allow the Commissioner of Health to be quite clear about the kinds of things that he or she needs to consider in developing a designated area. Essentially, the code of practice and the designated area must be one and the same. That was the reason for including the Commissioner of Health in this legislation. It is a little different from the way this has previously been approached. We are not removing the power from the Nurses Board because the Nurses Board will make the final recommendation about the code of practice. However, we believe that it is essential that the Commissioner of Health and the Nurses Board are in accord with what the code of practice actually is.

Once the Commissioner of Health and the Nurses Board have developed the code of practice, the Commissioner of Health, acting in concert with the chief nursing officer, will ensure that the designated area and the things that can be done within that designated area reflect the provisions of the code of practice. It simply closes the circle. It does not transfer power from one body to the other; it simply puts them in partnership and requires them to collaborate to develop the practice codes and the way they are applied within the protocols that will be designed for the designated areas.

Dr J.M. WOOLLARD: I came into the Chamber a little late, so I missed some of the member for Murdoch's earlier comments. However, I heard some of the minister's explanation. I queried proposed subsection (2a) and

was advised that it had been inserted in the Bill because under the Poisons Act, the Radiation Safety Act, the Medical Act and the Nurses Act, the Commissioner of Health sets the boundaries. These Acts will set the boundaries for the code of practice. My understanding of proposed subsection (2a) is that the Commissioner of Health will review these Acts and state that they set the boundaries within which the nurse practitioner can function. The commissioner will inform the Nurses Board of WA of the boundaries and then issue the code of practice, which will come back to this Parliament to be either approved or disapproved.

Mr R.C. Kucera: That is correct; it will be tabled and it is disallowable.

Dr J.M. WOOLLARD: I am very happy to know that because, as the minister knows, I am very interested in the code of practice that will set the boundaries given by the Commissioner of Health. I hope that the code of practice will not be too narrow.

Clause put and passed.

Clause 6: Section 16 amended -

Mr M.F. BOARD: This clause provides that if a registration review committee of the Nurses Board is considering the registration of a nurse practitioner, a nurse practitioner must be on the registration review committee. I ask the minister to briefly explain how that nurse practitioner would be selected. Would the person be appointed for a certain time? Would the person be selected randomly or would there be some basis for the selection? Would that person be picked from a group of nurse practitioners that were available for that purpose? I would like to know how the process to select a nurse practitioner will work.

Mr R.C. KUCERA: The registration committee is a standing committee of the Nurses Board. It has an advisory panel of experts that advises on the various registration levels within nursing. The advisory panel will select the nurse practitioner. Once appointed to that committee, that nurse practitioner would be appointed for three years. That is similar to the other levels of registration. I might ask my advisers how that would occur in the first instance and how we will select the first nurse practitioner. In the transitional period we would need to take advice from the advisory panel and the standing committee. This clause intends that the advisory panel, on behalf of the standing committee, will select a nurse practitioner, and that person will be attached to the committee for three years.

Mr M.F. BOARD: The minister has precipitated my next question. Does the egg come before the chicken? Under the term of the transitional arrangements, will certain nurse practitioners be appointed to the board - as possibly the first nurse practitioners in the State - and act in that registration review committee?

Mr R.C. KUCERA: In the interim, we have obtained the services of a nurse practitioner from the United States. She will be attached to the education program at Curtin University. I expect that she will be part of the advisory role. The course will be accredited. People from that course will be selected when they have completed it, and they will be appointed under the transitional process.

Mr M.F. Board: Are you suggesting that the United States nurse practitioner will be on the review committee?

Mr R.C. KUCERA: No. She will be one of the first -

Mr M.F. Board: Will the first nurse practitioner selected to the registration review committee be appointed without the need for an additional qualification?

Mr R.C. KUCERA: Yes, that is the case - if any of the 32 students about whom we are talking is able to qualify. Nurse practitioners with appropriate qualifications from the eastern States are available. As the member is aware, under our mutual registrations, they are already qualified and could transfer immediately. The member is right that it is a question of whether the chicken comes before the egg. It is a circular situation; however, I assure the member that we will very quickly overcome it.

Clause put and passed.

Clause 7: Section 17 amended -

Mr M.F. BOARD: This clause provides that if a professional standards committee of the Nurses Board is to consider the professional conduct or the standards of a nurse practitioner, a nurse practitioner must be on the professional standards committee. The Opposition supports this clause, which works well in conjunction with clause 6.

Clause put and passed.

Clause 8: Second 22A inserted -

Mr M.F. BOARD: This clause provides that the Nurses Board must register a nurse as a nurse practitioner on payment of a registration fee if the board is satisfied that the nurse is entitled to be registered in division 1 of the register maintained by the board or holds an education or qualification that has been approved by the board. What is the process and how long does it take to become registered, particularly with regard to the education

qualifications? Can that process be accelerated? I understand it is a one-year full-time course or a two-year part-time course. Is there any other way to deal with that? What might happen in the transitional arrangements with regard to this clause? The Nurses Board must maintain the register. Further clauses will deal with any nurse practitioners who have not practised as nurse practitioners for three years. According to the Bill, they must notify the Nurses Board that they will no longer be able to practise as a nurse practitioner before upgrading their skills. The emphasis seems to be on the nurse and not on the Nurses Board to maintain the register. What happens if that fails to happen and errors are made? Where is the emphasis in that regard and who takes responsibility for any errors in the system?

Dr J.M. WOOLLARD: The minister has stated that there will be mutual recognition. I am a bit concerned about the member for Murdoch's comments, because they implied perhaps a lack of professionalism. At the moment nurses register with the Nurses Board of WA. They are responsible for their own registration by identifying, from their qualifications, in which part of the register they will be placed. Although I may believe that, under this Bill, the scope for nurse practitioners is too limited and narrow, I am sure that the minister will assure the member for Murdoch that professional nurses will be appointed nurse practitioners. As such, when they complete their registration, they will be well able to identify whether they have been practising as nurse practitioners or registered nurses.

Mr R.C. KUCERA: I thank the member for Alfred Cove for those comments. They are professional appointments, and we would expect nurses to follow the protocol, not only in this process but also in divisions 1 and 2. Prior to employment, nurses are required to confirm their registration, and they must also demonstrate their recency of practice. There is a requirement on nurses to do that. It works very well under the process in the other divisions; I see no reason that it will not work in this instance.

I will put on record the statutory requirements for registration as a nurse practitioner. Registered nurses must be registered or entitled to be registered in division 1 - I understand enrolled nurses are in division 2 - hold an educational qualification approved by the Nurses Board and pay an application fee for the assessment, and registration is renewed on an annual basis etc. Nurse practitioners who have not practised for a period of three years or completed a qualification or refresher course within that period are removed from the register. The member for Murdoch is quite right that there is a requirement on nurses to show that they are registered and that their practice is current.

For the shortened process, there are entry requirements. A non-degree entry requires registration in division 1 and then three years or 5 000 hours relevant post-registration clinical experience. A person is then required to meet the criteria for an alternative mode of entry - for example, a portfolio or an interview. Degree entry is pretty well self-explanatory. There is a bachelor's degree, registration in division 1 and three years or 5 000 hours of relevant post-registration clinical experience. In both instances, people would have to demonstrate their competencies in those areas. I will deal with the postgraduate diploma. A nurse practitioner must be registered by the Nurses Board of Western Australia as a nurse practitioner in division 1 of the register, having met all those requirements.

As I said earlier, during the transitional period there are two other ways by which a person could gain the nurse practitioner qualification. My understanding is that one way is by recognition of prior learning. There are those 32 remote areas about which we have spoken, and the nurses from there may very well be able to demonstrate their competency, their length of practice and the fact that they are already registered in division 1. There will be the capacity for the Nurses Board to declare that that is sufficient for a person to be qualified as a nurse practitioner. The next way, of course, is for a qualified nurse practitioner who comes from another State or another country to be able to show that he or she holds that qualification and has the degree of recency required.

Clause put and passed.

Clauses 9 and 10 put and passed.

Clause 11: Section 27 amended -

Mr M.F. BOARD: Clause 11 allows for temporary registration procedures to apply to registration as a nurse practitioner. Clarification is needed of exactly what is intended under the legislation regarding these temporary registration procedures. Are they part of the transitional arrangements? How or why would a nurse register for a temporary position? Would it be because a nurse believes that he or she has satisfied the requirements of the Nurses Board, in a practical sense, or has occupied a position that may be deemed to be in a designated area of need? That would certainly be the case for a number of nurses who are already in areas that have been earmarked in that sense. Other nurses who may be working in the metropolitan area may qualify for some other reason, such as past performance. Nurses may have worked in a similar position in another State of Australia, and they may feel that they have the personal qualifications to apply for temporary registration under this clause.

Mr R.C. KUCERA: This applies simply to those people who are already recognised as nurse practitioners and hold the qualification. This registration usually applies to those people who may come to Western Australia to work on a temporary basis.

Mr M.F. Board: This applies only to people who qualified interstate?

Mr R.C. KUCERA: Yes, already qualified; or it may very well be somebody who has qualified in Western Australia but wants to work in a relief position in a designated area for a short term.

Mr M.F. Board: But they must be already qualified?

Mr R.C. KUCERA: Yes.

Mr M.F. Board: It is not a temporary registration?

Mr R.C. KUCERA: No. It is not a sideways move into the process, and once a person has finished his or her term, he or she is out of it again. The member is quite right. It is about people who come from overseas or from other States. They must be qualified.

Mr M.F. Board: Under the transitional arrangements in this legislation, those who work in a designated area will be able to apply for recognition. Does that apply only to those who feel that they can apply because they have worked in areas in Western Australia, or does it apply to, say, other remote areas in the Northern Territory and Queensland?

Mr R.C. KUCERA: No, the simple answer is that we are talking about this State, and the transitional arrangements are for Western Australia; they are not for other places.

Clause put and passed.

Clauses 12 and 13 put and passed.

Clause 14: Section 30A inserted -

Mr M.F. BOARD: This clause provides that, on registration, a nurse practitioner can practise as such and use the title "nurse practitioner" in connection with that practice, but only while he or she is carrying out duties as a nurse practitioner in a designated area. This means that a person registered as a nurse practitioner cannot use the title "nurse practitioner" in connection with his or her practice at any place other than a designated area. This needs some clarification by the minister. I appreciate that there will be some very proud nurses in the State who will receive recognition as nurse practitioners. Accordingly, they may print some business cards, personal cards or cards associated with their current designated area. However, on the cessation of a nurse's time in that position, that nurse may find that he or she is no longer working in a designated area but may be advertising himself or herself as a nurse practitioner. What constitutes the promotion of a person as a nurse practitioner? What constitutes the advertising of a person's accreditation as a nurse practitioner? We must be sensible in this situation. However, we could be talking about an e-mail address, or advertising in the *Yellow Pages* or the *White Pages*, where people often include their credentials.

We need to clarify, for the record, what is and is not acceptable in the legislation. This issue was discussed during the second reading debate. In other words, an architect is an architect, an accountant is an accountant, and a solicitor is a solicitor whether or not they are unemployed. The situation for nurse practitioners is unusual in that, all of a sudden, these people can go from reaching the pinnacle of their nursing career, in a clinical sense, as nurse practitioners, to not even being able to mention that they are nurse practitioners, depending on how one interprets the provisions on advertising and promotion. This is an important area that needs to be clarified.

Mr R.C. KUCERA: There is nothing wrong with nurse practitioners calling themselves registered nurse practitioners. It is not the intention of the legislation to stop them from doing that. However, they cannot hold themselves up as practising as nurse practitioners unless they are employed and work in designated areas; it is as simple as that. It is the same as a person being recognised as an accountant by the letters after his or her name. If a nurse practitioner is not working in that field, she cannot hold herself out as practising as a nurse practitioner. That is what the legislation says. The bottom line is the bottom line. Even though a person may be a nurse practitioner, she will not be paid as a nurse practitioner unless she is working in an area designated for that practice.

Mr M.F. BOARD: I understand the matter clearly. I will present a scenario; it could be a very real situation. A qualified nurse practitioner may be on leave or travelling and may come across an emergency situation. It may be in a remote area of the State. Some pressure may be put on the nurse practitioner from an outside body or whatever to act as a nurse practitioner. What would be the legal situation for a nurse practitioner in that situation? What protection would a nurse practitioner have or what liability would she face if she acted as an independent nurse practitioner outside a designated area and these provisions were tested in court?

Mr R.C. KUCERA: If a person were to work outside the code of practice, it would be no different from a division 1 or 2 nurse; she cannot do that. Emergency situations are very different. Provision is made for that generally within practice. The simple issue here is that a person cannot hold herself up as a nurse practitioner in an undesignated area and start to practise the protocols of a nurse practitioner. It is as simple as that. It is no different from saying that there is no provision for acting further outside the code of practice. The reality is that this happens within health services in emergency situations. The intent of this clause is to ensure that a person cannot practise as a nurse practitioner unless he or she is working within a designated area.

Dr J.M. WOOLLARD: I query some of the comments of the member for Murdoch. One assumes that a nurse who has undergone a program to become a registered nurse may call herself a registered nurse. If that person then underwent further training to become a nurse practitioner, one would assume that she could use the term "nurse practitioner" on her business cards, in the telephone directory or wherever. For most people, this would be quite natural. I have not heard of a question such as this being raised in Parliament before. I believe that some chiropractors call themselves doctors even though they do not qualify for that title. I have never heard a question on the titles used by other groups. However, all of a sudden the Opposition seems to be expressing a concern about nurse practitioners using that title. I do not know where that concern is coming from.

Mr M.F. Board: No, we are supporting it. That is where we are coming from.

Dr J.M. WOOLLARD: The member for Murdoch's comments did not imply support.

Mr R.C. Kucera: I certainly did not infer that from the member for Murdoch's comments. I thought he was supporting it. I do not agree with the member for Alfred Cove.

Mr M.F. Board: I do not know how you can turn things around all the time. We are supporting the fact that nurses should be able to carry the title with them. That is what we are saying.

Dr J.M. WOOLLARD: Why did the member for Murdoch ask the question then? Surely it is automatic.

Mr M.F. Board: Because nurses are concerned about being sued.

Dr J.M. WOOLLARD: For using the title?

Mr M.F. Board: Yes; in a phone book, in an email address or on a business card. The legislation is unclear. That is why we need to put on the record the minister's support for their usage of the title, even if they are not occupying that position, so that it is clear that they can use that title.

Dr J.M. WOOLLARD: In that case, I am pleased that the member for Murdoch arranged for that to be put on the record, if he believed that there was a concern.

Mr R.C. KUCERA: It may clarify this issue if I advise both members that the Nurses Board of WA has general guidelines for advertising for all divisions of nursing. Those guidelines will also apply to nurse practitioners. I put on record that the intention of this legislation is not to stop nurses from using that title. However, they will not be able to practise as nurse practitioners unless they are in a designated area.

Clause put and passed.

Clauses 15 and 16 put and passed.

Clause 17: Section 36 amended -

Mr M.F. BOARD: I require a quick explanation from the minister. As is the case in most professional areas, a qualification is evidence of who a person is. In this case it is evidence of registration. However, the emphasis seems to be entirely on nurse practitioners to maintain and keep up to speed their credentials and registration at all times. There does not appear to be a sharing of that load. I raise this issue to satisfy the member for Alfred Cove that the Opposition supports the fact that nurse practitioners will be a professional body. However, under this clause, the entire responsibility, at all times, seems to be on nurse practitioners to maintain their credentials within the system. There does not seem to be any emphasis on the department or the Nurses Board keeping records up to speed or helping. For example, someone could be qualified as a nurse practitioner but may move between positions and, over a period of a few years, no longer practise as a nurse practitioner. Those people would drop off the register. Under clause 18, the emphasis is on those people to notify the Nurses Board that they no longer practise in that area and thus they would drop off the register. If, for example, a nurse practitioner in that situation wanted to advertise or practise as a nurse practitioner, she would find herself liable for not having notified the Nurses Board within a three-year period. Is that an overemphasis on the need for nurse practitioners to maintain registration? Is there a need for the Nurses Board to also maintain a register and share some responsibility in this regard?

Mr R.C. KUCERA: Firstly, the Nurses Board does maintain a register. This is no different from any other division of nursing. In fact, it is no different from any other professional organisation or association. People are expected to take some responsibility for the currency of their certificates of registration.

Mr M.F. Board: The difference with most other professional bodies is that once you are qualified, you are always qualified. The difference here is that a person not occupying a position is no longer qualified.

Mr R.C. KUCERA: A person will always be qualified, but he or she will not be registered.

Mr M.F. Board: The qualification drops off after three years, unless the qualification is maintained.

Mr R.C. KUCERA: The registration drops off after three years. The qualification remains, but must be refreshed.

Mr M.F. Board: That is the same thing.

Mr R.C. KUCERA: It is not the same thing.

Mr M.F. Board: I will put it this way: if a nurse does not occupy a position for three years, he or she cannot keep up.

Mr R.C. KUCERA: That is quite right, but it is no different from a doctor who is practising, or other people who are required to have currency of practice in any of the fields of health. All we are saying here is that registration lapses, and that in order to get back on the register and to be allowed to continue practising, the person must prove his or her worthiness for registration. As well as that, there are requirements within the framework for employers to be responsible for maintaining opportunities for undertaking professional development in the areas of practice. While a nurse practitioner is continually working, this is not an issue. For the people who drop out of the nurse practitioner area, their registration will lapse after three years, but their qualification will still be there, and will just need to be revitalised and refreshed.

Mr M.F. BOARD: This might be the appropriate time to raise the issue of the uniqueness of what we are doing here. Nurse practitioners, particularly those in designated areas now, who may be entitled to registration will have very different backgrounds and clinical experience. They may have been required to do very different things, and have differing access to support mechanisms. A person who moves from a nurse practitioner position in location A to location Z may face entirely different pressure and require a different level of skill. Will their credentials be generic? That may be the case for those that do the full-time course, and are qualified by that process, and keep up that qualification, but it may not be for those who receive their qualification by a different method. I am not against that; I totally support it. However, there will be a different skill set and skill level. How will the skill set of nurse practitioner in location A be matched to the designated need in location Z?

Dr J.M. WOOLLARD: I question the comment of the minister about the registration being the same as that for medical practice. Maybe the minister will clarify whether medical doctors must reapply for registration every three years, the way this Bill has stipulated for nurse practitioners. I do not believe that to be the case, but I am happy for the minister to point out if I am incorrect. At the moment, to allay some of the concerns of the member for Murdoch, if registered nurses do not practise for five years, they lose their registration. It would have been far more suitable for this Bill to allow the same length of time, so that there was no difference between the categories of nurse. The minister has stated previously that these nurses will have special skills and will therefore need to be monitored more closely, but these nurses are at the pinnacle of the career structure. With the litigation occurring today, they will certainly be doing their very best to ensure that they keep up with ongoing education, in whichever area they are practising. It is inappropriate for this Bill to state three years; it should state five years. There is no need for these nurses to be singled out from other registered nurses. They are very senior, professional nurses, and with this new role, and because they have waited and striven for this role for so long, they will certainly not slip behind in their nursing skills and education.

Point of Order

Mr R.C. KUCERA: The member for Alfred Cove appears to be talking about clause 18 of the Bill. That matter can be dealt with when we reach that clause, but I understand that clause 17 is before the House now. I did not want to jump in, but I think the member jumped ahead a clause.

Dr J.M. WOOLLARD: I apologise; I did jump ahead a clause in responding to some of the comments made by the Opposition.

Debate Resumed

Dr J.M. WOOLLARD: In the area of registration, one can rely on the nurses to ensure that their skills are up to date; and, if not, as the minister mentioned before, refresher courses and ongoing educational course will be made available to them.

Mr R.C. KUCERA: Clause 17 deals simply with physical evidence of registration, nothing more and nothing less. I will answer the issues raised by the member for Murdoch, and also the issues in relation to clause 18. Firstly, in the case of the nurse practitioner who moves from one area to another, the protocols would dictate a job description, and the nurse practitioner would not be expected to meet every criterion of that job description. As I said earlier, under the framework there is a requirement for upskilling in the designated area. The requirement is there, in the area of employer responsibility. Of course, we would not expect somebody to move from, say, an emergency department in Perth to a remote area and find them to be the same. Obviously, when the employer is considering the curriculum vitae of that nurse, I would suspect the nurse would have laid out how he or she intended to meet the criteria. There would be a requirement for upskilling, and there is a requirement in the framework for that to occur.

I will just move on very quickly to the reason for the three years. Firstly, this period was recommended by the steering committee.

Mr M.F. Board: That refers to clause 18; we should deal with clause 17 first.

Mr R.C. KUCERA: My apologies.

Clause put and passed.

Clause 18: Section 41 amended -

Mr M.F. BOARD: The minister will need to clarify whether the nurse practitioner who has not practised for a three-year period, or does not complete a qualification or a refresher course approved by the Nurses Board within that period, will be deregistered. They will be removed from the register, and I call that deregistration. In the second reading debate the House dealt with Curtin University's full-time and part-time courses for those wanting to qualify as nurse practitioners. We have not dealt with and nor has there been any explanation about the requirements for a refresher course? Where will these courses be available? What will be their duration? Will the refresher course cover various specialties or will it be generic? Who will determine the content of the refresher course? In other words, as the minister mentioned earlier, nurses leaving emergency area work are no longer able to be registered for that area because they do not occupy a position and they no longer need to upgrade their skills. However, when moving to another position, the upgrading of their skills may be entirely different from what is required for another individual entering a similar position. Who determines what the refresher course requirements will be compared with the nurse practitioner course and will various refresher courses be available? Will the minister provide some clarification?

Mr R.C. KUCERA: First, nurses do not have to do the refresher course if they have been practising continually. Secondly, options will be available. Bearing in mind that we have three years to develop the refresher course, I do not anticipate that the course will be required before then.

Mr M.F. Board: But it might be.

Mr R.C. KUCERA: I cannot anticipate that it will be required. In any case, the refresher course would be based on the current course that is being developed. That was the reason, as I mentioned earlier, for the importation of a qualified nurse practitioner to assist with that process. However, the course will be based on the current course and approved by the Nurses Board of WA.

Mr M.F. BOARD: I can foresee many situations when there will be a demand for a refresher course long before the three-year period is up. Nurse practitioners may be appointed because they currently occupy a designated area. However, they may feel, on transferring to another area of need such as the metropolitan area, that they need some upgrading of a particular skill based on their transferring to a different clinical experience. A nurse practitioner from another State may have a qualification based on her experience but may not have practised in this State. She may want to apply for a nurse practitioner position in this State, but will need to upgrade a particular skill that is needed to work in an isolated area of the State. That refresher course may be needed long before the three-year period is up. I suggest that this be seriously considered.

Mr R.C. KUCERA: There is some confusion over this provision. A nurse must do a refresher course if she needs to re-register. If a nurse moves from one area of practice to another, there is a requirement to upskill or do professional development courses, which is different altogether. For instance, if a nurse is going to work in an area where she needs to prescribe drugs, she would need to undertake the pharmacological course, which takes about one month. However, that is different to being re-registered. The former is a requirement within a designated area. A nurse could still be employed within that designated area but, under the codes of practice, she could not carry out that part of her role unless she was recognised as having the competency. There is a generic requirement under the code of practice that once a nurse has qualified for that code of practice, she can be registered. In order to work in a particular area, a nurse must be able to carry out the duties in that area. Those duties are governed by the framework of protocols put in place. Members will remember that I talked earlier about the overlapping of the generic code of practice with the protocols. A requirement for a nurse to carry out a

particular health service within an area of practice is a different kettle of fish. If the employer accepts a nurse on the basis that she needs upskilling, it is the employer's responsibility to upskill the nurse; it is not her responsibility.

Dr J.M. WOOLLARD: The provision states that the board shall remove from the register the name of any person registered as a nurse practitioner who has given notice or not practised as a nurse practitioner -

The DEPUTY SPEAKER: I am having difficulty hearing the member with the call. Can the members talking on my right be mindful of that for my sake, for Hansard's sake and for the sake of others listening.

Dr J.M. WOOLLARD: Will the minister reassure me that whilst the nurse's name will be removed from the register of nurse practitioners, they will not lose their registration if they have not practised for three years? Will they still keep their registration until the five years has elapsed, as is the case for all other registered nurses?

Mr R.C. KUCERA: In that case the nurse's registration will simply drop down to a normal division 1 nurse. She will not lose her registration. The reason for the three-year period was that it was the view of the committee that because of the added responsibilities, such as the prescribing and use of various drugs, there was a necessity to keep that skill current.

Dr J.M. WOOLLARD: The minister stated that it was the "view of the committee". Earlier, when referring to clause 4 and the definition of "designated area", I was informed that this definition arose from the recommendations of the committee. Would it be possible to see the terms of reference of the committee that reviewed the role of the nurse practitioner and to read some of the minutes from its meetings? I have considered the make-up of the steering committee that included academic deans of nursing, remote area nurses and representatives from the Royal College of Nursing, the Nursing Board of WA and the Australian Nursing Federation. I am surprised that having had representatives from those areas on the steering committee, the Bill was written the way it is, particularly in relation to clause 4.

Mr R.C. KUCERA: We are too far down the track to respond to that kind of request. All the reports were placed on the web. A broad consultation process was undertaken by all stakeholders, including the ANF and others that were involved. The steering committee was very eminent. I do not see how I can assist with the member's request. I am more than happy for the member to look at the web site where she will find all the information she needs. It can be found under "Remote Area Nurse Practitioner Project Report 2000" or www.nursing.health.wa.gov.au. The information is there for everyone to see.

Clause put and passed.

Clause 19: Section 42 amended -

Mr M.F. BOARD: This clause is a bit loose. I say that because this clause provides for the restoration of the name of a person who has been removed from the register as a nurse practitioner on satisfying the nurses board that she meets the requirement for re-registration, which is fine. However, we have already stated as a result of that that there is no criterion for restoration of a name to the registrar. In other words, there are no refresher courses in place and we do not know what the registration criteria will be. Therefore, whilst it is important that the nurses board has the power to re-register, we do not know what the criteria will be for that restoration. What requirements must those nurses meet? Such criteria have yet to be determined. We know that, initially, nurse practitioners had to register as nurse practitioners. However, having been removed from the register, what refresher course will they be required to undertake? Such a course has yet to be developed. The explanatory memorandum states that nurses must meet the Nurses Board's registration requirements, but we do not know the detail of those requirements.

Mr R.C. KUCERA: Clause 19 seeks to amend section 42, which is also applicable to other divisions of nursing. In order to satisfy the Nurses Board, a nurse practitioner must meet the same criteria that had to be met upon initial registration. It is about meeting the requirements of the registration. For example, it may well be that a nurse's registration has lapsed because she has not paid her registration fees. The clause seeks to extend section 42 to nurse practitioners, as has been done for division 1 and 2 nurses.

Mr M.F. Board: The educational requirements that must be met if nurses become deregistered because of a lapse in registration or because they have not practised for a while are much clearer than they are for nurse practitioners. Nurse practitioners might have to meet additional educational requirements before becoming re-registered; however, such requirements are not yet in place.

Mr R.C. KUCERA: I am advised that it is no different from other divisions of nursing. Nurses in other divisions must also meet certain requirements every three years. The clause seeks to extend the existing legislation. We must not confuse the requirements of the code of practice in registration with the requirements of a specific job description, which is very different.

Clause put and passed.

Clause 20 put and passed.

Clause 21: Section 47 amended -

Mr M.F. BOARD: The explanatory memorandum states that this is an offence provision and provides that a person shall not use the title of "nurse practitioner" unless he or she is registered as a nurse practitioner. That is fair enough. It also provides that it is an offence for a person to hold himself or herself out to be practising as a nurse practitioner unless he or she is practising as a nurse practitioner in a designated area. When it comes to hanging up a shingle or publishing an advertisement - whether via publications, business cards, the telephone directory, an e-mail address or any other means - using the term "nurse practitioner" while not practising as a nurse practitioner will not attract a fine or be seen to be in breach of the Act.

Mr R.C. KUCERA: It is exactly the same as clause 14. Clause 21 outlines the penalty if a person breaches the intent of clause 14. I have been quite clear about that. As I understand the matter, as long as an advertisement meets the Nurses Board's advertising guidelines, there would be nothing wrong with a nurse practitioner putting an advertisement in the jobs wanted column that states "Qualified Nurse Practitioner wants job". As has been stated throughout the debate, there is nothing wrong with a nurse carrying the title of "nurse practitioner". However, a nurse practitioner cannot practise as a nurse practitioner unless it is in a designated area. It is not the intent of the legislation to preclude nurse practitioners from carrying that title or from having it appointed alongside their name or after their name on a business card or an e-mail address.

Clause put and passed.

Clause 22: Section 48 amended -

Mr M.F. BOARD: It is quite clear that under the legislation it is up to nurse practitioners to maintain their registration. However, it now becomes an offence for a person to hold himself or herself up as a nurse practitioner unless registered. If people were to hold themselves out to be nurse practitioners while somehow failing to make it known that it had been three years since they had practised as a nurse practitioner - as I understand the situation, even though they might be qualified they lose the qualification if they have not been practising - the onus falls on the nurse practitioner to maintain that position. In other words, it becomes an offence if nurse practitioners distribute business cards or do not cancel an advertisement if they are no longer registered because they have not practised for three years. This will create a situation in which a person's registration is lost because they have printed something or put something into the *White Pages*. There will be an overlapping period. How will it work in practice?

Mr R.C. KUCERA: The clause is quite clear. I do not have a problem with it at all. We are not talking about the qualifications of nurse practitioners; we are talking about their registration. If registered nurses fail to register and then hold themselves out to practise as registered nurses, they will commit an offence. It is exactly the same for nurse practitioners. A person can be qualified as a nurse practitioner, but unless he or she is formally registered with the Nurses Board, which is a requirement to practise, the person will be committing an offence. If the registration has lapsed for reasons that the nurse is not aware of, obviously it becomes a matter for consideration by the Nurses Board, and I am sure there would be grounds for defence.

Mr M.F. Board: The onus is on the nurse practitioner to notify the Nurses Board if there has been a three-year lapse since they have occupied a position. Therefore, they could no longer be registered as a nurse practitioner.

Mr R.C. KUCERA: They have to do that upon the renewal of their registration. That is one of the reasons the three-year period applies.

Mr M.F. Board: If I advertise myself as a nurse practitioner and lose my registration because I do not have a job - even though I had been trying to get a job for 12 months - I am no longer able to hang out my shingle even though I might have circulated business cards or had certain information printed in the *White Pages*.

Mr R.C. KUCERA: It is no different from the other divisions of nursing. There is a requirement on nurses to comply with the registration processes and procedures. The idea of people hanging out their shingle as a nurse practitioner -

Mr M.F. Board: It is a new appointment.

Mr R.C. KUCERA: People can certainly carry the title. No-one has a problem with that. A person cannot set himself up; for instance, he cannot go down to Hay Street and say that he is going to open a surgery as a nurse practitioner. It does not work that way.

Ms A.J. MacTiernan: Hay Street where?

Mr R.C. KUCERA: I will not take that interjection!

There is a requirement on nurses to be registered. If they fail to comply with the registration process, they will be in breach. It is no different from any other division of nursing.

Clause put and passed.

Clauses 23 and 24 put and passed.

Clause 25: Section 19 amended -

Mr M.F. BOARD: We are now dealing with an amendment to the Medical Act 1894 and amendments made to that Act in 1984. This clause goes to the heart of the legislation. It provides an exemption for nurse practitioners for certain services and advice that are normally only provided by a medical practitioner. Exemptions already exist for dieticians and chiropractors giving chiropractic advice or dietician services. The exemption is to apply only in circumstances when the nurse practitioner is carrying out functions as a nurse practitioner. Will the minister clarify whether the exemptions under the Act are exemptions already laid down in the code of practice?

Mr R.C. Kucera: They will be spelt out in the code of practice. In turn, that will be reflected in the protocols built into the definition of the particular designated area that a nurse practitioner is working in.

Mr M.F. BOARD: If the exemptions are to be widened, what will be the process for widening under the Medical Act?

Mr R.C. KUCERA: My understanding is that those services and advice can only be within the framework of the legislation. If that were to be extended, a further amendment would be needed to the Medical Act. That is my understanding.

Clause put and passed.

Clauses 26 to 29 put and passed.

Clause 30: Section 8 amended -

Mr M.F. BOARD: This clause deals with an amendment to the Misuse of Drugs Act 1981. This clause allows for an extension of provisions pertaining to obtaining prohibited drugs from a medical practitioner or dentist by fraudulent behaviour to also include obtaining them from a nurse practitioner through fraudulent behaviour. I require some clarification from the minister. I understand the situation in the city. What is the situation for people who have been acting in this capacity until now? Has there been any protection? If not, I can understand why we need to amend the legislation.

Mr R.C. Kucera: Remote area nurses are not permitted to prescribe drugs; they can only supply them. This affects only schedule 4 drugs, which are restricted. I doubt there has been a circumstance that would come under the provisions of the Misuse of Drugs Act.

Mr M.F. BOARD: Does this also apply to over prescribing caused by fraudulent behaviour? I am also talking about patients who appear repeatedly asking for drugs that are not prohibited.

Mr R.C. Kucera: My understanding is that situation would fall under the rules of the Health Insurance Commission. The fraud would concern payment. I am not sure but my understanding is that it would not be an offence in respect of remote area nurses. We are talking about antibiotics and those sorts of drugs.

Mr M.F. BOARD: As I understand it, the intent of clause 30 is solely to extend to nurse practitioners the same protection that exists for general practitioners and dentists under the Misuse of Drugs Act.

Mr R.C. Kucera: The Misuse of Drugs Act is being amended to include nurse practitioners in the same area as a medical practitioner or dentist when fraud is committed. It is not a protection. It simply means that if a person obtains drugs from a nurse practitioner by fraudulent means, he is committing an offence in the same way as if it had been done through a medical practitioner or dentist. It is an inclusive clause.

Clause put and passed.

Clauses 31 to 35 put and passed.

Clause 36: Section 20 amended -

Mr M.F. BOARD: This clause amends the description of schedule 1 poisons, as detailed in the Poisons Act 1964. The amendment includes the possibility of the availability of poisons from a nurse practitioner in addition to availability from a medical practitioner, pharmaceutical chemist or veterinary surgeon. The descriptions of schedule 1 will be amended. Schedule 4 will also be amended to cover the prescription or supply by a nurse practitioner in addition to prescription or supply by a medical practitioner, dentist or veterinary surgeon.

What protection against legal liability will be given to nurse practitioners? Will nurse practitioners acting independently be given exactly the same liability as is afforded medical practitioners employed by the public health system? Will they be offered full coverage under the normal provisions of the public health system?

Mr R.C. KUCERA: Yes. The coverage will be exactly the same as that afforded to any other person working within the medical system. Nurse practitioners will be afforded exactly the same cover as others if they work within the code of practice, and will attract the same liability if they work outside the code of practice.

Clause put and passed.

Clauses 37 to 39 put and passed.

Clause 40: *Poisons Regulations 1965* amended -

Ms M.M. QUIRK: Clause 40 is an interesting clause in that it purports to amend provisions that are contained not within the Nurses Act but under the Poisons Regulations 1965. At first blush, this is a somewhat unusual procedure. Ordinarily, regulations are amended by subsequent regulations. The Joint Standing Committee on Delegated Legislation, which normally scrutinises regulations, has taken the unusual step of considering this clause. Although the committee considered it to be a somewhat unusual mode of amendment of regulation, it did not, as a matter of principle, see anything wrong with it. It noted that this form of amendment is probably not a course that should be followed as a matter of routine, but it could see no legal impediment to its being done in this case in the manner described.

Mr R.C. KUCERA: I agree with the member for Girrawheen. Although it is not usual for a Bill to amend regulations, the amendment to the Poisons Regulations were considered an important part of the overall scheme and were therefore included in the Bill to provide a comprehensive package. I acknowledge that it is not normal practice. People have waited a long time for this legislation. The amendments to the Poisons Regulations were included on advice from the Joint Standing Committee on Delegated Legislation. This clause ensures that those amendments will come into effect on the same day as the other provisions in the Bill. There will be no delay in that regard.

Clause put and passed.

Clause 41: Regulation 2 amended -

Mr M.F. BOARD: I would like some clarification about this clause, which I find a little confusing. The clause notes read -

> This clause amends the definition of "supply". The definition of supply prior to this amendment provides that administration to a patient of any substance specified in any Schedules of the Act by a medical practitioner, dentist or registered nurse when acting under the direction of a medical practitioner is not deemed to be supplying.

That is fair enough as in that case the nurse would be working under the direction of the medical practitioner. The notes continue -

> The amendment provides that administration to a patient of any substance specified in any Schedules of the Act by a nurse practitioner is also not deemed to be supplying.

Who would be supplying in that situation if it is neither the medical practitioner nor the nurse practitioner? I am confused about the purpose of the clause.

Mr R.C. KUCERA: My understanding is that the purpose of this amendment is twofold: firstly, the coverage of this clause is extended to a nurse practitioner who is permitted to supply a drug under the code of practice; and secondly, the clause applies to a nurse practitioner acting under the direction of a medical practitioner. The clause simply includes nurse practitioners in the regulations. That is my understanding.

Mr M.F. BOARD: That makes perfect sense. That is not how the clause notes read. The Government is adding nurse practitioners to the list of people who might be directed by a medical practitioner. What would be the scenario in the case of a nurse practitioner acting independently?

Mr R.C. KUCERA: As I explained, if the nurse practitioner is acting within the code of practice, there is no offence of supply. Obviously, if the nurse practitioner steps outside that code of practice and acts without the direction of the medical practitioner, the consequences would be no different from those that apply to anybody else within any of the divisions of nursing.

Clause put and passed.

Clause 42: Regulation 11A inserted -

Mr R.C. KUCERA: I move -

> Page 17, after line 10 - To insert the following -

(3) The Commissioner of Health may not designate an area, or amend or withdraw a designation, under this section until after receiving written advice with respect to the proposed action from the officer of the department who is principally responsible for providing advice on matters related to nursing.

I thank the member for Alfred Cove for developing this amendment, which is sensible under the circumstances. I also thank her for her interest in the legislation. The purpose of the amendment is to provide that the Commissioner of Health must receive written advice from the chief nursing adviser in the Department of Health before making any decisions about the designation of an area for the purposes of employing a nurse practitioner. This goes to the heart of some of the comments that were made earlier about designated areas and making sure that there is a complete circle in the development of designated areas. I commend the member for Alfred Cove for making sure that the nursing profession has a very strong hold on the issue of designated areas.

Dr J.M. WOOLLARD: I support this amendment. The minister is well aware that I would have liked this proposed subregulation to be much stronger; however, I am pleased that it will be included in the Bill. It is very important that the chief nursing officer or acting chief nursing officer be fully involved in the nurse practitioner legislation and that this function stay within the domain of nursing. The addition of proposed subregulation (3) would give the nursing profession some guarantee that its concerns would go to the Commissioner of Health. Also, because the chief nursing officer would put the nursing profession's advice in writing, if any applications were rejected or if there were a need to withdraw a designation, the nurses would be able to apply under freedom of information to find out the rationale for the changes. That would assist them in the continued development of their role.

Mr M.F. BOARD: The Opposition will not oppose this amendment. However, I am not sure that it will give effect to what the member for Alfred Cove is trying to achieve, because the Department of Health employs the chief nursing officer. This amendment in no way changes the power for the director general to designate what the areas are. I would be very surprised if the director general did not seek the advice of the chief nursing officer in any case. We will not oppose the amendment, although I do not think it has the strength or provides the input from the nurses that the member for Alfred Cove seeks in order to protect the nurses' input into these designated areas. As I said at the outset, the Australian Medical Association has made representations to the Opposition. The AMA has proposed some amendments, one of which relates to this area. It is likely that the Opposition will move an amendment in the upper House in terms of designated areas and advice received from an independent advisory committee. The AMA has suggested an amendment that would remove the power of designation from the director general and place it with the Minister for Health. That advisory committee ought to be represented by a number of people from the nursing profession who are independent of the Department of Health. I do not in any way want to belittle the position of the chief nursing officer; I totally support that position and what it does. However, I do not believe that the amendment achieves what the member for Alfred Cove wants. I support what she is trying to achieve, but I think the amendment should go further and be stronger. The Opposition will consider the AMA's proposed amendments in more detail; I received them only today. I understand its position, and the Opposition will examine those amendments. I foreshadow some possible amendments in the upper House. We will not oppose the member for Alfred Cove's amendment, because it at least adds a bit more to what we currently have.

Mr R.C. KUCERA: I am disappointed that the Australian Medical Association has seen fit to bring amendments before the House only today and has absented itself from the process of consultation for its own reasons. One would have to question its motives. However, I will not go any further into that at this time. I would be disappointed if, at a later stage of the legislation, it was defeated because of the interests of a group of people other than nurses, which is exactly what happened when it was introduced into this House almost 20 years ago. This legislation is about nurses and first-class nursing. The member for Alfred Cove's amendment is a very strong amendment, and I congratulate her for it. Her amendment is needed to reinforce and cement the role of nurses making decisions about what their code of practice and their protocols should be. I do not believe that decisions should be made above the Director General of Health and be given to the Minister for Health. The decision would then become a political decision rather than a decision based on the quality of care and practice that nurses would be expected to carry out in a designated area. I fully support and commend the amendment.

Mr M.F. BOARD: I assure the minister that this Bill is all about strengthening the role of nurses. The Opposition gives its total commitment to support the Bill

Mr R.C. Kucera: I realise that the member must place before the House the suggested direction.

Mr M.F. BOARD: Correct. This legislation will strengthen the role that nurses play in the decision-making process about where designated areas might be; it is also about an independent body. The minister said that decisions made by the Minister for Health would become political in their nature. However, that is already the practice in the designated areas of need for general practitioners; the minister must sign them off, yet he does not

consider that to be political. I see no difference between being able to designate an area of need for a nurse practitioner and for a general practitioner. Hence, it is logical to have a similar process operating. It could also be said that the director general would be under the pump with regard to the financial considerations and concerns about his budget and how that would be allocated, whereas the minister considers the policy and protects the interests of the community as an elected member. As a result, I think that in these instances there is a precedent for the minister to play a role with regard to a designated area. I do not consider that to be a conflict; I believe it would be consistent. We will consider that matter in further detail and discuss it within our own areas. I think that in some ways the member for Alfred Cove's amendment gives strength to what we are trying to achieve in the overall direction of the nurse practitioner legislation.

Dr J.M. WOOLLARD: I too am concerned by the Australian Medical Association's concerns for this legislation. The member for Murdoch has stated that in the upper House the Opposition will seek to delete the "Commissioner of Health" from this amendment and will seek to set up an independent advisory committee.

Mr M.F. Board: I said possibly.

Dr J.M. WOOLLARD: If the Opposition is implying that the Commissioner of Health should be deleted from this clause and replaced with an independent nursing advisory committee, I am sure the nurses would have no difficulty with that. However, I dare say that the AMA is seeking an independent advisory committee that is made up of representatives from the AMA and the universities. That would make it a political committee as responsibility would be taken out of the professional area. I would like the chief nursing officer to designate the areas for the purposes of this Act, perhaps in consultation with an independent nursing advisory committee, but I certainly would not like solely to have an independent advisory committee of unknown representatives. I would question the member for Murdoch's support for this Bill if members of the Opposition in the upper House move that it go to an independent advisory committee, unless that independent advisory committee is an independent nursing advisory committee.

Mr R.C. KUCERA: I do not think I can add to the member for Alfred Cove's argument. I support the amendment. I believe it places a much stronger onus upon the chief nursing officer to make independent decisions about the advice he or she would give to the Director General of the Department of Health. I will use the member for Murdoch's corollary of areas of need. There is an administrative requirement for that to be referred to the Minister for Health, because that is an exchange of delegations between the State and federal Governments. The federal Government is involved in the provision of provider numbers etc. As I understand it, a transfer of powers is involved; therefore, it must necessarily go to the minister.

Under this legislation, a designated area is within this State and is governed by state legislation. As the minister, I am comfortable accepting this amendment and the intent of this legislation. The intent of this part of the legislation is to make sure that nurses have a clear input into what should be a designated area, the protocols for that area and the actual practice. The difficulty that the member for Alfred Cove raised is that perhaps people other than nurses would decide what would and would not be practised in that area. I would hate to see a situation similar to that which arose in New South Wales.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 43 to 51 put and passed.

Clause 52: Section 26 amended -

Mr M.F. BOARD: We are now dealing with amendments to the Radiation Safety Act 1975. Clause 52 provides that a nurse practitioner, acting in accordance with a code of practice issued by the Nurses Board of WA under the Nurses Act 1992, does not need to hold a licence for the purpose of requesting the holder of a licence under the Radiation Safety Act 1975 to undertake any diagnosis or therapy. Medical, dental or veterinary practitioners are not required to hold a licence for that purpose. Will the minister clarify the situation under this clause, particularly with regard to the board? There has recently been some publicity about radiographers, in particular about what is happening in country areas as against the metropolitan area. We are dealing with nurse practitioners in not only country areas but also the metropolitan area. We need clarification of how this will work for a nurse practitioner as a result of the latest board decisions and decisions the minister has made about the metropolitan area.

Mr R.C. KUCERA: Firstly, the situation that arose in some of the outer suburbs would be considered in the light of the protocols that would be developed for that, if there were an application for a designated area. Certainly, under those circumstances, that practice would not be included in the protocols designed for that area, because if there were the capacity to have a radiographer in that area, obviously that would not be part of the requirements, and if that criterion were applied, that business case would not stand up.

I will go back to the intent of this clause. It is important to note that this amendment does not allow a nurse practitioner to undertake any diagnosis or therapy, but only to order it. Therefore, nurse practitioners are not practising the art of radiography; they are simply ordering it. At the moment, in many instances, even in the emergency departments in the metropolitan area, a nurse may be aware that a person needs an X-ray of a broken leg, but she cannot order it. She must wait until a clinician orders it. This legislation will at least allow her to get the process under way, but it will not allow her to read the X-ray or to make a diagnosis from it. That is not the intent of the legislation.

Mr M.F. Board: What about conducting the X-rays?

Mr R.C. KUCERA: I will go on to that in a second. The Radiological Council has the capacity to issue licences to undertake diagnosis or treatment on the completion of a one-month course provided by the council. That implies two things. First, it implies that if the Radiological Council is satisfied that the nurse practitioner in that area has completed the course and it feels that that practice can be included in the protocols for that designated area, everything is in order. Once the council is of the opinion that the nurse has completed the requisite one-month course and that that practice can be undertaken, it will issue a licence to the nurse practitioner. Nurses and nurse practitioners who may be required to take X-rays must have completed that course and hold a current licence.

The amendment allows nurses to order diagnostic investigations. Limitations on the range of investigations that they can order will be through the clinical protocols that are approved as part of the process of designation. This goes back to the heart of this legislation. We are talking about a collaborative effort in setting up teams in which these practitioners will operate. There must be agreement by the Radiological Council that that take place. It is expected that nurse practitioners will order X-rays, but not more detailed testing such as magnetic resonance imaging or computerised axial tomography scans. Because of funding considerations, there are limitations on the extent to which nurse practitioners in the private sector would be able to order diagnostic testing. In other words, we get back to the issue of the provider number, which this legislation does not address. They also would not have provider numbers under the commonwealth Health Insurance Act.

I will summarise quickly. Nurses would need to undertake a course approved by the Radiological Council. The area would need to be approved by the Radiological Council as a designated area. When those two things come together, the nurse will be issued with a licence that will allow her to operate within the protocols for that designated area.

Mr M.F. BOARD: It is reasonably clear, but it becomes complicated because of recent decisions of the Radiological Council, which the minister supported. I use Mundaring as an example. What would happen if a doctor at that clinic wanted to employ a nurse practitioner and continue business but would be, as it were, flying in the face of the geographical boundaries that the council recently put forward? Because there are no radiology services at Mundaring, would Mundaring be considered an area of need, based on the fact that 85 per cent of the people who attend that clinic - according to the information we have, if it is correct - come from areas east of Mundaring; that is, they come from country areas to access that clinic? That should be considered an exemption and the boundary should perhaps be changed, but that is something for the Radiological Council and the minister to decide. It disadvantages many in our community. I understand the need to maintain standards, but it seems that an arbitrary line on the map does not always work; there needs to be some flexibility. What happens when trying to attract a qualified nurse practitioner, in this sense, and then applying for designation as an area of need? How would that situation be dealt with?

Mr R.C. KUCERA: Firstly, on the point raised about Mundaring by the member for Murdoch, as minister I must be guided by the Radiological Council. I have no option in that regard. The guidelines it lays down are based on safety, and it is difficult for me, as minister, to go outside those guidelines. In fact, I do not think it is possible for me to go outside the guidelines on issues of safety, and nor would I, particularly when it comes to radiation.

Mr M.F. Board interjected.

Mr R.C. KUCERA: The advice given to me by the Radiological Council was that it did not consider that that area was suitable and that a radiographer was required. I must take that advice, because it is based on safety considerations. If it were a designated area, a nurse practitioner would not be able to practise under that part of the protocols because he or she would not be licensed to do so. On the other hand, if we were designing a set of protocols for that area as a designated area, it would not include the capacity for that task to be carried out, unless there was agreement from the Radiological Council to do so. In any case, the nurse practitioner would not be licensed to operate that machinery.

Clause put and passed.

Clauses 53 and 54 put and passed.

Clause 55: Savings and transitional -

Mr M.F. BOARD: This final clause of the Bill is an important clause, because it allows for transitional arrangements for applications made within six months of commencement of the amended legislation. Clause (1)(b) allows for a nurse who has carried out functions similar to those of a nurse practitioner within the previous three years to carry out the functions of a nurse practitioner in a designated remote area nursing post while an application for registration as a nurse practitioner is dealt with. The clause also provides that a person who applies under the transitional arrangements may be registered as a nurse practitioner without holding formal qualifications, if the Nurses Board is satisfied that that person has sufficient knowledge and practical experience to carry out the functions of a nurse practitioner. The Opposition supports the transitional arrangements; I do not have a problem with them. However, some clarification of the transitional arrangements is needed for *Hansard*, particularly with regard to the provision for nurses who have carried out functions similar to those of a nurse practitioner within the previous three years. The clause does not specify whether this must have been for the whole of the three-year period - according to the notes we have been given, it could have been one month within the previous three years. Some clarification is needed on the period. Who determines what are similar functions? Is that done on an individual basis? In other words, are the functions and background of each nurse and the requirements of the position examined individually, or will those decisions be made solely on the designated areas and the person who has been practising in those areas? Clarification is needed of how these transitional arrangements will work. There are many questions about the transitional arrangements and the process by which they will work.

Mr R.C. KUCERA: Firstly, the Nurses Board will decide on the registration of nurse practitioners. The department will decide on designated areas under the protocols we have spoken about. The Nurses Board will have to satisfy itself that a nurse has the required level of knowledge and practical expertise to competently and efficiently carry out the functions of a nurse practitioner. As to whether it is the whole or only part of the three-year period, the Nurses Board will have to make a judgment call. It will be responsible for assessing the prior knowledge and expertise of applicants under the transitional arrangements. For instance, the Nurses Board may also require an applicant to undergo further or additional training if gaps are identified. I am talking about the code of practice for nursing. Once that has been decided by the Nurses Board, it will provide for registration. The Department of Health will work with Curtin University of Technology and the Nurses Board to develop guidelines for the professional portfolios that will be submitted to the Nurses Board as part of the applications of each nurse from these remote areas. There will be no blanket approval. Each case will be treated on its merits and considered individually by the board. The transitional arrangements provide that these nurses may practise as nurse practitioners while their applications are assessed. However, they will still be subject to the clinical protocols that operate at the remote area nursing posts. Members should bear in mind that most of those protocols are already in place. There are designations for those remote area nurses. The decisions of the Nurses Board on registration, including the transitional arrangements, are subject to the appeal provisions set out in the Nurses Act. There is also an appeal process within the Local Court. In summary, each case will be considered on its merits and the Nurses Board will make a judgment call on what it considers to be a sufficient level of prior knowledge.

Mr M.F. BOARD: That is reasonably clear, although it is discretionary. I can understand the need for that. I refer to two possible scenarios. The first is a case in which a nurse who has been practising in an area that will become a designated area does not, for some reason, meet the criteria of the Nurses Board for a nurse practitioner, but wants to stay in the area and may not want to do the course to qualify as a nurse practitioner. The second scenario is that of a nurse in a designated area who does not want to apply for this additional responsibility or qualification, even though he or she might be practising in this area. However, the director general of the Department of Health may feel that a nurse practitioner is needed in that area. What happens to that individual and the protection of his or her position in that circumstance?

Mr R.C. KUCERA: It depends on the health service itself. There is a capacity to provide for dual designated areas under the transitional arrangements, which would retain the classification of the area as a remote area. If that were the case, the nurse would continue to practise as a remote area nurse but would not carry the designation of nurse practitioner and, obviously, would not receive the benefits that go with that.

Mr M.F. Board: Would they be covered under the legislation for liability?

Mr R.C. KUCERA: Yes, under the Poisons Act regulations as they currently stand. There would be no change.

Mr M.F. Board: It would only be the same protection as they have now?

Mr R.C. KUCERA: Yes; there is no change. It may well be that a health service would not apply for a particular area to become a nurse practitioner area; that may not be required as the health service may be comfortable with the current designation. If that were the case, the nurse would not have to apply. In the case of a nurse who felt that his or her skills were not sufficient, two things would happen: there would either be an up-

skilling of that person to take on that designation, or he or she would simply be allowed to continue to practise as a remote area nurse within that remote area designation.

Mr M.F. BOARD: Is the minister saying that, as part of these transitional arrangements, if a current nurse who happens to occupy a position in a designated area does not want to move, there would be no way that that person would be encouraged or forced to move from that position and be replaced by a designated nurse practitioner?

Mr R.C. KUCERA: A simple answer is no; there will be no forcing. We are short enough of nurses as it is without applying force.

Clause put and passed.

Title put and passed.

Third Reading

MR R.C. KUCERA (Yokine - Minister for Health) [9.11 pm]: I move -

That the Bill be now read a third time.

MR M.F. BOARD (Murdoch) [9.11 pm]: The Opposition is very pleased that this legislation is before the House today. If we have any criticism, it is that this Bill has been longer in coming than we anticipated. We are also very pleased that it is met with almost universal acceptance in Western Australia. Although there are various opinions about that level of acceptance, it is an important piece of legislation that will further not only the career of nursing but also the opportunities for the Western Australian community to access first-class nursing and medical care. The Opposition places on record its support for those who made this happen, particularly the Government, Justice Kennedy and her committee, and all those who played a role through the nursing and medical associations at all levels. Those associations played an advisory role in this legislation.

This is significant legislation, which leapfrogs Western Australia from a trailing position in the development of "clinical practice" to the head of the game. It provides not only for the role of nurse practitioner, but also for a greater number than in any other State, and moves towards what other countries are doing to provide opportunities for general practitioners to utilise the skills of highly qualified practising nurses. It also provides the opportunity for an extended career for clinical nurses. We have already indicated in the House on many occasions that it is a shame that, under our current system, our most proficient and highly qualified nurses move out of clinical practice into administration, solely to further their career, their influence on the profession and their salary. While, from a patient's point of view, they do not entirely remove themselves, that is what happens. As I have indicated before, we would be better off having career structures for nursing in this State, both administrative and clinical, that ran in tandem. There may be some streams that people will be able to opt into through the process, rather than having to go into administration at the most highly qualified stage of their career.

This in no way removes the need for general practitioners in this State, or our desire to train more medical practitioners. The need for medical practitioners is at the coalface of medical care in this State, and the emphasis needs to be maintained on attracting medical practitioners to all areas of practice, whether in regional or remote areas, outlying parts of the metropolitan area, or any other areas of need, particularly in the area of public health itself, where they are employed by the public health system. We need to attract general practitioners into the developing areas of population health, primary health care or any other area. The area of prevention will play a much larger role in determining the long-term health interests of Western Australia. We have seen, through the advent of some of the lifestyle diseases, such as diabetes, that prevention can ease many problems and complications in later life, particularly in the cost of delivering the public health system.

We are yet to see the applicability of this legislation to the private health system, or the not-for-profit health system, and whether it will have an application as a result of these designated areas. We are yet to see whether general practitioners themselves will be able to employ nurse practitioners in designated areas of need, and what their relationship will be. That is an important aspect of how this legislation will develop. Some of the concerns that have been expressed by the Australian Medical Association, the various divisions of general practice, the colleges and so forth, while they support the general thrust of the legislation, show some fear of the unknown, and of what the relationship will mean in the long term. I can understand that, because we are breaking new ground. The ground we are breaking is important, because we are advancing the interests of our community and the nursing profession, and that must be good for Western Australia. In doing so, it is incumbent on the Government and the minister to bring everybody with them. In the medical area, that is not easy; we are all aware of that. It is much better to move people along in a way that helps them understand where the divisions lie. The major concerns of general practitioners in this State are about the relationship with and the independence of the nurse practitioner. Is that to be a semi-supervised or coordinated role, or is it to be totally independent? What will be the long-term scenario if that independence leads to clinical decisions being made,

and even clinical practice being conducted, by nurse practitioners outside of any consultation with medical practitioners? Will it lead to a change in the way drugs are dispensed, and will nurse practitioners eventually be employed in pharmacies to act in a consultative way in the area of public health? Who knows where these changes will lead? I understand the fears of those who have invested a great deal of money and time in providing a first-class health system to the State. They want to be assured that the public interest will be maintained, and I assume that they also want to make sure that the interests of their profession will be maintained. I see nothing wrong with that, so long as they act with the interests of the community at heart. That involves getting the balance right, which is the responsibility of the Government.

I have foreshadowed to the minister that some amendments may be moved in the upper House. Whether the Government, and the other parties in that place, will support those amendments is a matter for negotiation. We will move those amendments in the spirit of trying to make this legislation work better for all parties.

When determining the areas of need, it may be in the long-term interests of the State to use an elected member, and that may be a better model than using the public sector and the director general. The minister's responsibility is to the people of the State, whereas the director general must adhere to the legislation and the policy of the Government of the day. As a result, under huge budgetary constraints and perhaps feeling some pressure, the spirit of the legislation may be applied in an even more flexible way than what might be intended by the Government of the day. That remains to be seen and explored as we move on.

The Opposition supports the legislation. Contrary to some of the statements that have been made, the legislation will provide more strength to the arm of nurses in this State. On some other day, the Opposition would like to revisit the Nurses Act and make further amendments to add to the career structure of nurses and to provide the opportunity for student nurses not necessarily to be employed as student nurses, but to be paid for work experience within the hospital system or some other systems. This would provide greater certainty to the nursing profession and the opportunity for nurses to learn as they are educated.

The Opposition congratulates the Government on getting to this stage with the legislation and it looks forward to seeing the provisions of this Bill work within Western Australia.

DR J.M. WOOLLARD (Alfred Cove) [9.23 pm]: As a registered nurse I am pleased to see this legislation pass through the House and to hear that the Opposition is giving bipartisan support to this Bill. I am disappointed that the Bill contains a definition of "designated area" and that this theme appears throughout the Bill. I would have preferred - as I am sure would many nurses - that once a nurse had undergone the educational program to become a nurse practitioner, she could then move from one area to another and not be restricted by whether a business management plan had been prepared by the health service appointing nurse practitioners in various areas.

This legislation is 10 to 12 years out of date. In this State nurses have been practising as nurse practitioners without the full support of legislation such as this. When this Bill passes through the other House, some 30 to 40 nurses in remote and rural areas could be almost ready to be registered as nurse practitioners with the Nurses Board of WA. Many nurses working in various metropolitan areas will also apply under the grandfather clause to be registered as nurse practitioners.

I am pleased that the code of practice will return to this House for review. I fear that this legislation may have been designed to provide a quick fix for the remote and rural sector. However, a review will establish whether this legislation genuinely supports the role of nurses that has evolved and will continue to evolve.

I am disappointed that the member for Murdoch has foreshadowed that some amendments may be put on the Table of the upper House in response to the late input from some health groups, particularly the Australian Medical Association, which has, until this date, chosen not to contribute to the Bill.

This Bill has been needed for many years and it is relevant now. Although the minister refuses to accept that the health care system is in crisis, I firmly believe that this Bill will go a long way towards alleviating that crisis by formally recognising the role that nurse practitioners can play in the system. One then must look to the future in relation to this Bill. What has been suggested in terms of future development is not fully within the powers of this Parliament. All members know that doctors and nurses work closely together and have very good relationships, particularly in the area of general practice.

Some concerns were expressed tonight about the erosion of the role of the general practitioner. As I said earlier, far from erosion of that role, there is bipartisan support in this House for the Government to encourage the federal Government to provide more places for medical students in Western Australia to allow for more doctors in the Western Australian health care system. Yes, one can advertise university places and reregistration courses for nurses. However, if we considered nurses' workloads and job satisfaction, we might be able to prevent

nurses from leaving the health care system. We need more nurses, but the minister should address the issue by dealing with job satisfaction and workloads rather than advertising more places.

With regard to the future of the nurse practitioners' role, because of their close relationship with general practice, once this Bill is passed, the Government must consider lobbying the federal Government and linking the nurse practitioner role with GP provider numbers. Nurses will then be able to play an active and supportive role for general practitioners in general practice as well as other settings.

I support the intent of this Bill. I do not support the fact that it provides for designated areas. However, the minister has given an assurance that this provision will not interfere with the support for the role of the nurse practitioner. We will have to wait and see how the code of practice is written and whether, over the next six to 12 months, nurse practitioners are appointed under this Bill into designated areas. The nursing community is greatly concerned that, by leaving this definition within the Bill, the scope of the nurse practitioner role will be limited.

I commend the Government for progressing the Nurses Amendment Bill 2002, which has been hanging around Parliament for many years. I am sorry that the Bill does not go all the way; however, it is definitely a step in the right direction. I look forward to the legislation coming back into this House with the "designated area" provision removed. If not, at least we can move on and consider the code of practice to determine how we can develop the role of the nurse practitioner and improve the delivery of health care in this State.

MR R.C. KUCERA (Yokine - Minister for Health) [9.32 pm]: I put on record my appreciation of the role played by Dr Philip Della, Mrs Daphne Anderson and Ms Renay Shean in the development of the legislation. Dr Della's team assisted in making sure that the next phase in the development of the nursing profession moves on. I am pleased that the Bill has the support of the Opposition. Like the member for Alfred Cove, I am disappointed that the Australian Medical Association has chosen, at this late stage, to seek to insert amendments. I have not seen the amendments, but I will be disappointed if they go against the intent of the Bill, which seeks to truly recognise the work carried out by many nurses over a number of years.

Mr M.F. Board: There is no intention of that.

Mr R.C. KUCERA: I thank the member for Murdoch for his assurance.

There is no doubt that the Bill represents the next phase in the professionalisation of nursing. Today the House has considered both ends of the nursing spectrum; namely the administration of nursing and the development of the nursing profession. All of us support everybody who is involved in the process. I reiterate that the Bill is not about second-class doctoring - it is about first-class nursing. I hope that that intent alone is recognised as the Bill moves through the upper House. The Bill puts on record how this Government, and the Opposition, values the role of nursing in this State. It also recognises that the role of a nurse has moved on. In addition, the delivery of health services has moved on and worldwide we are faced with ever-burgeoning problems in the delivery of health services generally. It has been recognised that the professionalism and level of education of nurses has risen to the extent that they need to take their true place in the profession of care and in the provision of medical services generally. I am proud to be the minister who has introduced the Bill into the House. I am pleased with the support shown by the previous Government, which initiated the Bill. Today is a red-letter day for nursing. It will be an absolute red-letter day when the Bill passes through the upper House. I sincerely hope that the upper House considers the Bill in the spirit in which it is presented. It is a Bill that provides for great medical services and not one that seeks to consider the shortage of doctors. I commend the Bill to the House.

Question put and passed.

Bill read a third time and transmitted to the Council.