## HEALTH PRACTITIONER REGULATION NATIONAL LAW APPLICATION BILL 2023

*Second Reading*

Resumed from 7 November.

**MR D.A.E. SCAIFE (Cockburn)** [12.59 pm]: I rise to speak on the Health Practitioner Regulation National Law Application Bill 2023. I am going to focus my comments on the final tranche of reforms, which is the reform to protect the use of the term "surgeon". I am going to talk about this in the context of cosmetic surgery because it was concerns about the activities and regulation of certain practitioners in the cosmetic surgery business that led to this final set of reforms. As members will know, there are several tranches of reforms in this bill. We signed up to the national law approach in 2010, but we chose to sign up to it in 2010 through what is called a corresponding law mechanism. That means that the Parliament of Western Australia has to pass a corresponding law each time there is a national agreement about a new law to be passed. That means that if we do not pass the corresponding law, we will fall behind in the pace of reforms that have to be made to our framework for regulating health practitioners. We are quite far behind because we have not updated our laws for several years, and, as a result, I think we are three stages of reforms behind where we should be. I will speak about the fact that this bill will also introduce a uniform law approach to harmonising our law with the national agreement, but I will talk about that at the end.

There have been several tranches of reforms and the most recent tranche of reforms that is included in this bill deals with regulating the title of "surgeon". As things currently stand, the position title of "surgeon" is not a protected term. A medical practitioner with any qualification, including, say, a basic medical degree, could hold themselves out as being a surgeon. In the medical community, there is an understanding that when someone says that they are a surgeon, they mean that they have a long history of additional training and they often specialise in a particular type of surgery, such as cardiothoracic surgery or reconstructive surgery. There has always been an understanding in the medical profession that when someone identifies as a surgeon, it means that they have additional qualifications, training and expertise, and those qualities enable them to do surgical work. However, the reality is that the term has not been protected, so that has allowed people who do not have the extra training, qualifications and expertise to hold themselves out to the community as being surgeons. That has become a problem, particularly in the context of the growth of the cosmetic surgery industry over the past decade.

I want to talk about how we got to the point at which we need to protect the term "surgeon" whereas we previously did not need to and what is driving that. At the end of the day, if we track back the need to protect the term "surgeon" to the growth of the cosmetic surgery industry, we also have to track it back to the prevalence of body image issues in our society and the many ways that it is difficult for all people, but particularly young people, to be happy with the body they have. We see this particularly through social media. I have an Instagram feed, as I am sure many members do. My Instagram ads are full of content that tells me about the kind of body that I should have. It is interesting that my content has changed in the last few months. My content is now about how I can be a great dad but also really super-fit at the same time. It is about how I can have morning routines and still crush my day but be a great dad. I rather suspect that the male influencers producing that content are not the great dads they hold themselves up to be. It is interesting to me, as a man in his 30s, that the algorithm for my social media feeds is dedicated to shaming me about my body. As members would have noticed over the last six months or so, it is not the case that I have become a dad and managed to maintain a fit physique. I have enthusiastically eaten every calorie that has come within five metres of me over the past six months, and particularly the last three and a half months! I think there is something about living with the fatigue and stress that means that the only solution is to just keep putting fuel into my body to sustain myself, and I have enthusiastically adopted that approach to parenting. I am constantly shown images, stories and content that are saying that my body is somehow unacceptable and I should be dieting. It is quite interesting. I have been talking with my wife lately about the difference between the content on social media for women and the content for men. A lot of the same memes or gimmicks that come up on social media are mirrored for both men and women, but different lenses are put on them. At the moment, there is the "get ready with me" meme. The one for women tells them how they can detox their body, start their day right by drinking lots of water and live a healthy life, whereas the content of the men's version is the same but the lens is about how they can crush their day as a man. It tells them that if they start by drinking two litres of water and meditating, they are taking ownership of their life and that will lead to promotions at work and that kind of thing. There are still these archetypal sexist narratives in social media.

I think that social media has driven a lot of the anxiety that men have, but also, I want to acknowledge, that particularly women, young women and girls have. Although one in four people in Australia with eating disorders are men, that leaves three out of four people with eating disorders who are women. There can be no doubt that body image and eating disorders are a gendered issue. The member for Belmont will go into this issue in more detail. I promised her that I would not crib her material, so I am not doing that. The reality is that the intense focus that we now have on body image is driving a range of issues. It is driving eating disorders. It is driving other types of mental health issues. It is also driving the growth of the industries that prey upon people who are influenced by all those factors. I will leave the point about eating disorders to the member for Belmont, but I want to note that I was

at Cockburn Integrated Health with the Minister for Health a few weeks ago, and I was there myself on Monday and saw that the South Metropolitan Health Service's eating disorders clinic that is being opened at Cockburn Integrated Health is really coming along. I could see that the fit-out had happened and the signage was up behind the reception area, so I look forward to that service being opened. I congratulate the minister on leading the charge in addressing some really complicated issues of mental health and eating disorders, which are often intractable and difficult-to-treat disorders. I want to acknowledge the minister for her work on that and acknowledge that a service will be opening in my electorate thanks to the great work of this state government.

One of the things that I think we have probably all noticed that shows the growth of the body image industry over the last decade or so is the explosion in the number of gyms and wellness centres, which I noticed in the late 2000s when I was at university. Gyms were suddenly popping up out of the ground everywhere. More recently, I have noticed the growth of very small boutique cosmetic surgery clinics in shopping centres. I think there are at least two, or maybe three, in Cockburn Gateway Shopping City near my office. These shopfronts offer things such as waxing and those sorts of procedures, but they also offer all sorts of other things as well, like laser hair removal and injectables, a range of things that 10 years ago we did not hear much about. We certainly did not think we would be able to wander into a shopping centre, make an appointment and get that sort of procedure. I have noticed those sorts of outfits opening up.

We have also seen the rise of television shows about cosmetic surgery and the creation of celebrity personalities. Celebrity cosmetic surgeon, Dr Daniel Lanzer, who I will speak about a little later, has, I think, now fled the country because he was the subject of a lot of scrutiny from both the media and the regulator, and also on the receiving end of class actions from former patients. These celebrity medical professionals, or maybe paraprofessionals, buy into social media and buy into the body image issues that people have and create a whole online personality around it. The cosmetic surgery industry has become enormous in the last 10 years in particular. The estimates I could find were that the cosmetic surgery industry, excluding procedures like injectables and those sorts of procedures that people can have at shopfront clinics, is worth $1.3 billion to $1.5 billion. But if we include services like injectables, the value of the industry rises to something like $4 billion or $5 billion. This is huge money that is going into people's pockets. If people are going to be making that kind of money out of an industry, if they are going to be engaging in what are in many cases quite risky procedures, even the procedures that seem simple, or procedures that people can end up with a bad result from, it is right that it should have more regulation. It is right that we should crack down on the industry. I think it will be to the benefit of the industry itself. A lot of doctors have been supportive of these amendments, because they do not want to see public confidence in the medical profession lost as result of a few cowboys running around holding themselves out as cosmetic surgeons, when they really do not have the specialist training and expertise to do that job.

I now turn to some of the revelations that came out in the media around 2021 and 2022 about practices in the cosmetic surgery industry. A lot of different journalists were involved. Adele Ferguson led the charge in a coordinated investigation between the ABC and a couple of others, including *The Sydney Morning Herald* and *The Age*, which resulted in a series of programs and articles that exposed a lot of the problems in the cosmetic surgery industry. I will go to some of those examples from Adele Ferguson's reporting. I start with an article by Adele Ferguson in *The Sydney Morning Herald* from 21 August 2022. This article is entitled "'Please don't kill me': Elite soldier feared for his life after cosmetic surgeon cut him open". It really is a terrible article. I will not go into it in detail, but basically the article refers to a 24-year-old woman who had a procedure done by a supposed cosmetic surgeon, Dr Adam Najem. The procedure had seemingly gone wrong and it seemed as though the incisions had become infected. She went back to see him and he inexpertly poked and prodded around and caused her all sorts of pain and agony. The article states —

> The cosmetic surgeon, Dr Adam Najem, gives the patient gauze to bite on to stifle her screams "as there are other patients in the waiting room".

That is horrific behaviour. He sent her away that day and her condition got worse, but when she went back to him and his office he told her that there was no problem and that it is all part of the natural process after the surgery. The article says —

> Her condition deteriorates over the next few days but Najem advises her against going to hospital, saying, "No, it was all part of the procedure".
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> On June 4, 2018, the woman's cousin calls an ambulance, and she is admitted to the intensive care unit of Sydney's Liverpool Hospital in septic shock—a life-threatening condition.

It is just horrific for this woman and for her family. It also points to the fact that this patient or client of Dr Najem ultimately ended up in the public system, which had to pick up the pieces from bodgie work that had been done by someone in the private cosmetic surgery industry.

[Member's time extended.]

**Mr D.A.E. SCAIFE**: That is just one example of when things go wrong. I quote from another part of the article. It goes on to say —

> Najem runs a cosmetic clinic in Baulkham Hills, Sydney. On his website he describes himself as a reputable cosmetic surgeon who offers his patients "a high level of care".
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> But documents obtained as part of a joint investigation by *The Sydney Morning Herald*, *The Age* and *60 Minutes* into the $1.4 billion cosmetic surgery industry expose doctors like Najem. They reveal multiple serious failings in a poorly regulated sector that allows doctors with basic medical degrees and weekend courses to call themselves cosmetic surgeons.
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> …
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> Like most cosmetic surgeons, Najem has a basic medical degree and limited surgical training. He boasts as his credentials a certificate from the European College of Aesthetic Medicine & Surgery. But a quick look reveals this is an organisation that offers short courses in cosmetic surgery, including facelifts, which take 15 hours; or liposuction, which can be learnt in a four-hour online course followed by a hands-on training session.

This is the key point I made at the start about the use and protection of the term "surgeon". Here is a doctor who has a basic medical degree. They were a physician, but they were holding themselves out to be a cosmetic surgeon. The only additional training they had had was, essentially, through an online qualification factory that was ran short courses on what are, it seems to me as a layperson, some seemingly pretty invasive procedures that carry a lot of risk. That is an example of when things go wrong. We have had this financial opportunity for people to tap into body image issues and the wellness industry, then leverage their medical qualifications to perform procedures on people that they really do not have the skill and expertise to be doing. That is bad for health consumers and bad for medical professionals, because it runs down public confidence in the work they do.

I will give some other general examples of the range of problems that Adele Ferguson and various media organisations found. They obviously found examples like the one I just referred to of people who have been caused endless amounts of pain, like the woman in question who had gone into septic shock and had to go into an ICU at a public hospital, and also people who might not have been unwell but for whom the procedure had gone terribly wrong. I am referring here to the transcript of a radio program on ABC news titled "The horror that prompted the new cosmetic surgery rules" of 2 May 2023. This is an interview with Adele Ferguson. Samantha Hawley introduces her. The transcript states —

> **Samantha Hawley**: So that's just one case that you uncovered. What else did you find out was going on in this industry in Australia?
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> **Adele Ferguson**: Oh, there were so many things. What we found was it wasn't just the big practices that had problems. It was also the little practices that had problems. People were texting me saying that they'd had facelifts by smaller practices in Melbourne or Sydney or Perth. And you know, one woman said she looked like a monster. She didn't want to leave her home after getting a facelift that had just gone terribly wrong. Men were contacting me, they'd had penis enlargements and now they were in debilitating pain. It just went on and on. It was just horrifying.

They talk in the interview about other issues they discovered. They found that hygiene was an issue. There was a video from a whistleblower inside one of these cosmetic surgeries showing a fly in the operating theatre. Anyone who knows the health industry knows that it is completely unheard of and completely unacceptable to have a fly buzzing around while a procedure is going on. Nurses in the footage talked about cockroaches. They showed examples of nurses when the surgical instruments were not being sterilised on the site when they got to the site. The surgical instruments were just tossed in with doctors' shoes and dirty clothes, and fluids and other things were being drawn up in unsanitary conditions. There were real risks of contracting septicaemia and other types of infections. It is pretty awful stuff. I have spared the chamber most of the detail in these articles. They go into quite a lot of detail. I would encourage members to look this up and read it because although it is confronting, I think it is important and incumbent on us as public policymakers, to the extent that we can, to look this sort of stuff in the face and confront it. Clearly, a lot has been done by health ministers all around the country, including the federal health minister and all the state and territory health ministers. As a result of this bill and other reforms, I think we are addressing these issues and cleaning up the cosmetic surgery industry.

This is the important point: the cosmetic surgery industry is here to stay. I do not think many people in this chamber are prohibitionists on most issue. Obviously, we would be on some issues, but we have to be realistic as policymakers. This is a huge industry and clearly there is a lot of demand for it. I will let the member for Belmont talk about the sorts of things we should do to address eating disorders and the like, because there are many things we can do, but it is also about regulating the industry. If we cannot stamp out the industry, we can make sure that it is regulated properly and that people get a safe and professional service.

As I said at the outset, the key reform that I am referring to in this bill is the reform that protects the title of "surgeon". That reform provides that when someone says they are a surgeon, it will mean something very specific about what they can and cannot do and about their experience and qualifications. Importantly, under this bill, it will not matter if someone uses the word "surgeon" on its own. The word "surgeon" will be protected even if it is used in conjunction with other words. For example, if someone calls themselves a cosmetic surgeon or aesthetic surgeon, the word "surgeon" will still be protected. The bill gives an agreed meaning to the word and will also mean that through this bill and other reforms that protected meaning will find its way into all parts of society. A doctor will not be able to refer to themselves on their business card as a surgeon unless they meet the criteria for being a surgeon. They will not be able to advertise on social media or television and they will not even be able to introduce themselves as a surgeon or self-identify as a surgeon unless they meet the criteria. Importantly, this bill will enforce that by making it a new criminal offence for someone to use the protected title of "surgeon" if they do not meet the criteria of being a surgeon, and that offence will be punishable by a maximum fine of $60 000 or three years' imprisonment, or both. They are significant penalties for people who hold themselves out as surgeons and, in particular, as cosmetic surgeons when they do not have the proper training and expertise to be one.

I want to touch on the other reforms that have been brought on at the national level to address this issue. They relate to the policy generally speaking; they are not found within this bill. I want to acknowledge that the reform in this bill is situated within a series of other reforms. The first reform that has also been brought in nationally is that patients who seek cosmetic surgery will not be able to go directly to see a cosmetic surgeon. They will first have to see their GP and get a referral from the GP to see a cosmetic surgeon. I think that is great for a few reasons. It will enable that preliminary conversation between a GP and their patient and the GP can try to understand the motivations of the person who is seeking cosmetic surgery and they can have a conversation about whether it is necessary and why they think it is necessary. It will also mean that the GP can refer the patient to a specialist that the GP may be familiar with and knows what the specialist's reputation is like, and so there will be that extra level of quality control whereby the GP may not have all the knowledge but will have a little knowledge and can speak to the patient and find the right specialist for that patient.

The second set of reforms that came into effect just recently on 1 July are the new advertising guidelines. These guidelines provide that advertising for cosmetic surgery services must not be false, misleading or deceptive, must not offer discounts without terms and conditions, must not use testimonials and must not create an unreasonable expectation of beneficial treatment or encourage indiscriminate use. From 1 July, in addition to those requirements, will be the following requirements: medical practitioners must include clear information about their registration type and number. They need to say how they are registered; that is, whether they are registered under a particular specialty. I know that work is being done at the national level to create a cosmetic surgery specialisation that will allow people who hold the qualifications and expertise to be endorsed with that extra registration or qualification. In addition, ads must also have clear information about risks and recovery that must be easily found, videos and images must be used responsibly and not for entertainment, and videos and images must not be sexualised or include gratuitous nudity. The use of negative body language will be banned and cosmetic surgery advertising must be identified as adult content. These represent good protections around the use of cosmetic surgery advertising and the use of body image in advertising in a way that will elevate it to an adult audience and also mean that we will not use all that negative language and sexualisation around body image, which then drives people to use services that maybe they do not actually need.

In closing, I focused my remarks exclusively on that particular part of the bill. Although it is a very small part of the bill, I think it is a really important reform that points to a larger reform agenda that governments have been undertaking at a federal level and, to the extent necessary, at the state and territory levels. I know that this minister has always prioritised the health of young people and understood the difficulties of mental health issues and eating disorders, and this is another part of that. I commend the bill to the house.

**MS M.J. HAMMAT (Mirrabooka — Parliamentary Secretary)** [1.29 pm]: I also rise to make a contribution to the Health Practitioner Regulation National Law Application Bill 2023 that has been brought before us. I thank the member for Cockburn for his contribution. I was very interested to hear about the details of his Instagram feed. I feel it is probably an appropriate time to share that my Instagram feed is filled with Taylor Swift videos.

**Mr D.A.E. Scaife**: That's much better!

**Ms M.J. HAMMAT**: I know. Very cheery. Instagram has worked out that I am a fan of Taylor Swift and almost exclusively feeds me that content.

**Mr D.A.E. Scaife**: As a fellow Swiftie, I am jealous.

**Ms M.J. HAMMAT**: Yes. Anyway, it is better than ads for body image, so I can recommend that as a strategy.

In my contribution today, I will focus a bit on the issue of the health workforce and some of the challenges we face, not just here in Western Australia but globally, to meet the demand for the health workforce now and

particularly into the future. I will come to it in some more detail as I make my contribution, but this bill addresses the inconsistencies of the Western Australian regulations versus the national regulations. As others have said, in every other state but here, the national scheme works through the operation of the department in Queensland. Western Australia adopted the regulatory framework of a corresponding law mechanism to completely adopt an act replicating those national frameworks. It means that every time the national act is modified, we also have to make the amendment in Western Australia. As others have said, we have not kept up with that, and our regulatory framework is now different to the rest of Australia. This is not a unique provision for the regulatory arrangements of only health practitioners. The issue has also arisen in transport areas as well. It reflects a policy position that the former Liberal–National government took. It did not want frameworks in place in which the regulatory framework automatically flowed on in Western Australia. The problems with that have become evident over time. Fundamentally, the problem is that it is not an automatic adjustment to the regulatory framework; it requires specific pieces of legislation. When that does not happen, it ends up with inconsistencies. The whole point in having a national regulation scheme is to remove those inconsistencies to have a fairly efficient system. The heart of the issue is how we regulate health practitioners in a way that recognises their qualifications and delivers safe health care to the people of Western Australia. It really goes to the heart of the health workforce more broadly.

In commencing my contribution, I shout out to the people who work in our health system. There are a great number here in Western Australia. They are incredibly hardworking and professional, and day in and day out they deliver a first-rate, high quality health system that is safe for the people of Western Australia. I acknowledge that our healthcare workforce does not just comprise professionals like doctors and nurses, but also orderlies and cleaners in hospitals, all of the paraprofessionals. That increasingly large number of people in those allied health services contributes to maintaining our incredibly healthy and well population.

It is not new to say that the health industry faces pressures in meeting workforce needs, and it is not unique in Western Australia. It is a global trend. It is not new but it has become more acute. It has become apparent, I think, because of the demands that COVID-19 has placed on the health system. We have talked many times in this place about what that reality looks like. COVID was obviously a significant, once-in-a century issue managed primarily through our health system, but in other ways as well. Its impact had a long tail, partly because people deferred essential medical care or elective surgery. People who were in a position to defer treatment chose to do so rather than access healthcare during the height of COVID. It also had an impact through staff leave and other things as well. This does not just impact on our health workforce, it also increases community expectations about what health care will look like. It is about an increasing incidence of chronic disease and illness in the community, an increase in demand due to an ageing population and an increasing awareness of issues like mental health and disability. All of these things contribute to a need to focus on how we meet the needs of health workforces into the future.

As I said, it is not just a Western Australian or local issue, it is a global issue. For some time, The World Health Organization has turned its mind to a global strategy to address the human resources required for the health system around the world. Its plan aims to address that shortage of health workers by 2030. Part of its consideration in addressing the global health workforce is looking at the disparity existing around the globe as well. It is instinctively true, and I think people understand it is the case that, in a global consideration, there is not an equal distribution of where the health workforce can be found. Interestingly, WHO has also found that about 15 per cent of health and care workers globally work outside their birth country or the country in which they achieved their first professional qualification. I think that points to a fairly high level of mobility for the health workforce in moving around the globe to deliver its very valued services. Even though the contexts in which people might apply the skills they learnt as a health professional are different, they clearly are highly transferrable, and there is a high level of mobility in meeting the need that exists around the globe.

In Australia and Western Australia, we also rely on the skills of international health practitioners. This is nothing new. In fact, I mention a fairly recent piece of work that was undertaken by the federal government on an independent review of overseas health practitioner regulatory settings. Robyn Kruk looked at how we can have a more streamlined system to ensure that Australia is competitive in attracting international health practitioners to work here. This review identifies some of the gaps that exist Australia-wide for a whole range of health professionals. It identifies that there will be gap of about 10 000 by 2031–2032. We will likely need about 40 000 more nurses, and demands for allied professionals are also growing at a rapid rate. It recognises the increasing demand and the need for a regulatory system that allows us to attract overseas professionals. It is not just about attracting overseas professionals, because a key part of meeting that demand is our ability to encourage people to undertake the relevant training in Australia as well. I will come to that and some of the initiatives to increase that.

I will talk a bit about what the workforce looks like in Western Australia, using the data on the national register. As at June 2023, there were 88 806 on the national register with a principal place of practice in Western Australia. Our percentage of the national register is a little over 10 per cent and that is fairly consistent in terms of population. Western Australia is often around the 10 per cent mark. There have been findings of professional misconduct under that national scheme for 358 notifications relating to 271 practitioners. That scheme identifies where there are

problems and then takes corrective action. The scheme is doing its job to ensure that the health workforce is reliable and safe and that the workers are qualified to do what they claim to do. The member for Cockburn's contribution highlighted some of the problems with having people operating who are not well qualified to deliver services and the importance of having regulation to ensure that when consumers make choices about accessing services that they are well informed and they have confidence in the skills and abilities of the professional they choose.

I have talked a little about the health workforce in Western Australia under that scheme. It is interesting to consider the breadth of the health practitioner regulatory accreditation scheme. The scheme is responsible for a list of registered health professionals, including Aboriginal and Torres Strait Islander health practitioners, chiropractors, Chinese medicine practitioners, medical radiation practitioners, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, physiotherapists, podiatrists, psychologists, oral health therapists, dental hygienists, dental therapists, dental prosthetists, dentists, nurses, midwives and medical practitioners. It is a wide range of health professionals and, clearly, allied health professionals are an important part of that. It is easy to see why that would be the case; increasingly, people rely on allied health professionals to provide health services that are often preventive or early intervention to ensure that they are healthy and well. More than 642 000 health practitioners were working in registered health professions in Australia in 2020—105 300 medical practitioners, 350 000 nurses and midwives, 21 500 dental practitioners and 166 000 allied health professionals.

I note that my son Adam recently finished his physiotherapy degree and is in the process of concluding his registration to join the allied health professional workforce, so those numbers will increase by at least one, and no doubt substantially more. I take this opportunity to wish him well for his work in the allied health profession, a very important industry in Western Australia.

There has been a steady increase between 2015 and 2020 in each of those four areas. That is no surprise. As we understand, we need increasing numbers to meet demand. There has been an increase, and no doubt that will continue as current figures become available.

It is no surprise that Australia's health workforce is predominantly female. With the exception of medical and dental practitioners, more women are joining the industry but they are concentrated in occupational groupings such as nurses and midwives and in the allied health professions. The full-time equivalent rate of health professionals who are women remains at about 2.4 times that of men. There are substantially more women. They are not all working full-time and they are obviously in certain occupational groupings. There is concern about gender segregation in the workforce. I spoke earlier about the World Health Organization's work. One of the issues on its mind is not just meeting the demand for the health workforce, but ensuring that it addresses gender equality issues as well because that contributes to inequality in the labour supply.

I will move on to the history of this bill and how it sits in the scheme of work that has been undertaken, some of which is happening at a federal level. I will begin by referencing the *Sustainable health review: Final report to the Western Australian government*. The McGowan Labor government, now Cook Labor government, has had a commitment to ensuring that it delivers a first-class healthcare system for the people of Western Australia. One of the initial important pieces of work that was commissioned by the then Minister for Health, now Premier, was the sustainable health review. For the purposes of fully disclosing my interest in it, I was part of the panel that did the work on that in a previous role. It was a root and branch look at a strategic level at what were the things that were key to delivering healthcare for Western Australians—the strategies, initiatives and things that needed to be focused on to make a real and enduring difference to the health of Western Australians. Part of that was considering the role of the health workforce. The report identifies eight enduring strategies and makes a number of recommendations. One of those strategies deals with workforce issues specifically. The others considered things such as preventive health, mental health, strategies for early life and end of life and various other enduring strategies. The health workforce was part of the primary considerations, and that is because the health workforce has been key to the delivery of the healthcare Western Australians need, and will continue to be so.

That report predated COVID-19, so the work was done and the report tabled, and shortly after it was presented to government we found ourselves in the midst of dealing with COVID in 2020. It was an incredibly challenging time for our health system and, obviously, a time that required those in the health system to focus very much on that immediate and real risk. Some of those considerations perhaps overtook some of the considerations in the sustainable health review.

[Member's time extended.]

**Ms M.J. HAMMAT**: It is important to note that the workforce strategy talks substantially about not just the total number of people who work in that industry, but specifically about culture and ensuring that we have the skills and curriculum to develop the health and social care workforce of the future—a focus on ensuring that the supply pipeline of professionals has the skills and curriculum that will be incredibly valuable as we move into the future. Part of that is understanding that the context in which health is delivered is changing and that now more than ever we are considering interdisciplinary models of care rather than just professional-based approaches. I again reflect

on the work my son has done through his degree in learning to work with other professionals to understand what the best model of care is for a particular person.

The future also presents interesting challenges in technology with the recognition that technology changes and how and where healthcare can be delivered. Telehealth is the most obvious example of that. There is now the capacity for people to get health care using telehealth, even if they live in regional and remote areas. We saw a significant increase in that during the pandemic. There is no doubt that as technology changes, as is the case across all industries, it will challenge many of the ways those services can be delivered. The sustainable health review is an important piece of work because it turns the mind to what future challenges might look like in the workforce—not just in terms of supply but what are the right skills and how do we have the right structures for people to operate, not just in professional silos, for want of a better word, but in an interdisciplinary way.

We know that health is never static. The COVID pandemic illustrated that comprehensively—that need to change and adapt and to recognise how things are changing. As I said at the beginning of my comments, a number of things are driving an increase in demand for the health workforce for countries around the globe. They are things like an increasing awareness about chronic health issues and mental health issues, and increasing community expectations. Having the right workforce and maximising the workforce that we have is a really important public policy consideration. As I say, it has been on the minds of many policymakers and decision-makers for some time. I want to refer to the Productivity Commission's review into *Australia's health workforce*, which is a little dated now. It is dated 22 December 2005. It was a piece of work commissioned by the federal government for the Productivity Commission to give consideration to meeting those workforce issues. It looks at the ways the workforce issues could be addressed at a national level. The commission's objective in the report was —

> … to develop a more sustainable and responsive health workforce, while maintaining a commitment to high quality and safe health outcomes.

That really is both sides of the equation. It is about having a sustainable and responsive workforce but also ensuring we have the quality and safety outcomes that the community expects. The enduring focus on that is really key. There were a number of recommendations in the report and, given the time, I will not go through them all. A key recommendation was ensuring that we have national registration standards for health professionals, with the creation of a national registration board and supporting professional panels. A number of other recommendations go into profession-based accreditation. They recognise the particular difficulties for people who want to access health care in outer metropolitan or rural and remote areas, and in Indigenous communities, and the fact that targeted initiatives might be required to meet the health workforce needs in those areas. The report also recognises the need to have responsive health education and training arrangements. Again, training is a key part of it. For our purposes, the key recommendation was the question of national registration standards. It was from this recommendation in the report that we had the first federal legislation, which was adopted in 2010—the national registration and accreditation scheme for health practitioners. It is a regulatory framework. We adopted it through corresponding law. As I have explained, that requires us to pass legislation through this Parliament every time it changes. Other states adopted the scheme by way of national law, the host jurisdiction being Queensland. What would be required is agreement from commonwealth states and territories for the laws to be amended, then they would flow on automatically in other states but have to be addressed specifically here in the Western Australian Parliament.

This bill before us today is all about addressing the deficiencies that now exist in Western Australia's regulatory framework because a number of tranches of reform have applied to other Australian jurisdictions. This bill is about updating that and it is about ensuring that we have a nationally consistent framework. I want to address the importance of the nationally consistent framework because, as I have already said, it is partly about ensuring that we have a safe system so that people understand, if someone is registered as a health professional, they have met a certain standard of training and perhaps even a certain number of hours in delivering that service. It is also an important precondition to ensuring the health workforce is mobile around Australia. We often hear stories about sources of frustration if there are different regulatory systems in operation in different states and people have to either retrain or get re-recognised before they can practice their profession. That is clearly a disincentive for people being easily able to move from one state to another and enter into the workforce. I refer also to my earlier point about the work that has been undertaken to try to streamline overseas health workers and having a streamlined visa arrangement. Members can imagine the complexities there would be if there were different registration systems in every state, plus some fairly onerous visa requirements for people to be able to arrive here and start practising.

To ensure that we have the best access to the trained health professionals that we need, having a regulatory system means that we have the ability to have consistent, high-quality national professional standards around Australia. It also gives confidence to the public about what health services they are accessing. It supports mobility between states as well, either at the point of training or at the point of being able to commence working in the profession. That is why having a nationally consistent approach is so important. That is why this bill is so important; it will bring up to standard our regulatory system so that it is consistent.

Others have gone through the particular reforms that this bill will introduce. The member for Cockburn talked about the use of the title "surgeon", particularly as it is used in the cosmetic surgery sector. The laws will make that a protected title so it cannot be used by cosmetic surgeons. That is a very important initiative. It will also address changes that were made to the national regulatory framework in 2019 and in 2022.

In the short time remaining, I want to talk about a bit more about the question of training, because that is a key and important consideration. It is not just about labour mobility and whether it is labour mobility around the globe or within Australia. It is also about making sure we are encouraging people to pursue careers in the health sector and providing them with the training that they need to be able to do that. Of course, one of the initiatives that our government is very proud of and one of the things that I think is an excellent demonstration of the differences between a Labor government and a Liberal–National government is investment that we have made into TAFE and training. We have made significant investments into TAFE. That has benefited a whole range of different occupational groups, but there is no doubt that part of that has also been about encouraging people into health sector careers, specifically nursing. When the Labor Party was first elected in 2017, the McGowan government froze a whole range of course fees, which had been a huge disincentive for young people to enter certain professions. It is impossible to talk about the health workforce without pausing to reflect on what the Liberal–National coalition government did to fees for young people who were hoping to pursue a career in nursing. Between 2013 and 2016, for a diploma of nursing, it increased fees by 409 per cent.

**Mr T.J. Healy**: Shame.

**Ms M.J. HAMMAT**: Shame—that is right. It increased them from $1 878 to $9 467 over a three-year period. That is a 409 per cent increase. That is a significant deterrent to people choosing to study in what we know is a key area that we need, not just in economic terms, but in providing health and welfare for the people of Western Australia. The former government did that to a range of courses, including construction, and I think we are seeing some of the ramifications of that now in labour shortages as well. There is a stark difference between the approach that our Labor government takes to investing in young people and providing them with careers and opportunities, compared with what we saw when the Liberals and Nationals were in government. That has been further improved through the partnership with the Albanese government for fee-free initiatives. This ensures, for skilled workers in in-demand occupations, including nursing, aged care and disability care, people can undertake training in those areas without incurring any fees at all. That applies to a wide range of occupations but, for the purposes of this bill, it is very important.

I am almost out of time, but I want to commend the minister for the work she is also doing to increase the supply of labour for the health workforce. One of the important things is setting modern pay and conditions, particularly for nurses with the historic introduction of things like nurse-to-patient ratios and a range of other things. I am conscious that my time is almost up, so I will bring my contribution to an end. I thank the minister and I commend the bill to the house.

Debate interrupted, pursuant to standing orders.

[Continued on page 6410.]