C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

INQUIRY INTO THE PERFORMANCE OF THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

Melbourne—12 June 2013

Members

Ms G. Crozier	Mr M. Viney
Mr D. O'Brien	Mrs I. Peulich
Mrs D. Petrovich	Ms J. Mikakos
Mr N. Elasmar	Ms C. Hartland

Chair: Ms G. Crozier
Deputy Chair: Mr M. Viney

Staff

Senior Secretary: Mr Richard Willis

Witnesses

Australian Medical Council:

Professor R. Mortimer AO, President;

Mr I. Frank, Chief Executive Officer; and

Ms T. Walters, Deputy Chief Executive Officer.

The CHAIR—I declare opening the Legal and Social Issues Legislation Committee public hearing. Tonight's hearing is in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency. I welcome Professor Robin Mortimer AO, president of the Australian Medical Council, Ms Theanne Walters, Deputy Chief Executive Officer, and Mr Ian Frank, the Chief Executive Officer, of the Australian Medical Council. Thank you for being here.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. All evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website.

I now invite you to proceed with a brief opening statement, if you wish, which will be followed by members questions, and we have obviously received and read your submission, and thank you very much for supplying us with that. We look forward to hearing from you and asking questions.

Prof. MORTIMER—To summarise, Australian Medical Council is an independent national body that sets standards for medical training and assessment. We have been around for 28 years. We were originally formed by the jurisdictional health ministers and medical boards, and we had a limited range of roles when we began; one was to make recommendations to boards on accreditation of medical schools and, of course, is leading to basic medical qualifications. We were asked to assess suitability for practice in Australia of overseas trained doctors. We were also asked to try to bring Australia to uniform approaches to registration around the country. That started a long time ago.

Since then we have taken on some new roles. We have been asked for some years to advise the board and the Commonwealth minister on recognition of new specialties and we are in the process of becoming involved in the accreditation of pre-vocational training so it is internship leading to general registration. We are now the designated accreditations authority for medicine under the Health Practitioners Regulation National Law of 2009 and our roles are very similar to what I have already outlined, and I will not go through them again. We have worked with medical boards for a long time. When the National Law was enacted and AHPRA was established we had had considerable experience in dealing in this area. In 1992, for instance, we were involved in the establishment of mutual recognition for medical graduates across Australia.

We have worked very closely with the staff of AHPRA and we are contracted through AHPRA to the Medical Board of Australia to carry out our role, so there are three bodies involved in the accreditation of medical training. We are also a member of the Health Professions Accreditation Councils' Forum, and members of that forum I think are appearing before you soon.

I think in summary our relationships with AHPRA have been professional and productive and continue to improve the functioning of the national registration program. I could ask Mr Frank to tell us what has been happening since the introduction of the National Law.

The CHAIR—Thank you very much, Prof. Mortimer.

Mr FRANK—As Professor Mortimer has explained we have been pretty heavily involved in trying to establish uniform approaches to registration for medical practitioners in Australia for quite some time, and medicine I think had a slightly easier transition into the National Registration Scheme than perhaps some of the other health professions because since 1992 when the mutual recognition scheme came into operation in Australia, gradually over time the medical boards and councils in Australia managed to work quite closely together. When NRAS was mooted in 2005-2006 there was already a lot of work being done on developing uniform standards for ID checking for English language proficiency, for certificates of good standing and so on. A lot of work had been done across the state boards that established a national perspective or a national dimension in what was happening in medicine. The move into NRAS was I think for medicine a little bit smoother than perhaps for some of the other councils and bodies and professions.

We have worked, as Professor Mortimer says, very closely with AHPRA in those early days when AHPRA came into operation in July 2010. We received a lot of the overflow from the various calls that were being made to AHPRA about issues relating to registration, and because we had a little bit of knowledge in that area

we became a kind of de facto call centre for them until their own systems came into play and they gradually increased the capacity to deal with those calls themselves. Because of the work we had done in mutual recognition I think the AMC had a reasonably good appreciation of how complex the process really was. We are talking about 80 different regulatory bodies across 10 professions at the time and across eight states and territories amalgamating into a single entity. To put that in perspective, in 1992 we established mutual recognition in order to be able to track a practitioner across all the eight states and territories. We set up a database, a network, across the state jurisdictions to do that, and we found that while the data was the same in each of the jurisdictions in terms of the kind of categories of registration they had, what we found was no two systems were the same. That was just in medicine and at that time it was a huge task to bring those medicine groups together into a single entity that we could track an individual practitioner. At that time there were about 50,000 practitioners in Australia across those eight states and territories. Here we are talking about 500,000 practitioners across eight states and territories and across 10 professions. It was a much more complex task for that to get started and get going.

Our experience of the process suggested that in the rollout of the implementation there had been a bit of perhaps optimistic assessment of what was required in the task. Not only were we bringing all those bodies together but we were dismantling existing systems often losing a bit of expertise in the process, and then creating a new body that would take on all of those professions and move on from there. There was an added complication I think in that the model that was developed was a single piece of legislation where there are common features that would apply across all of the professions. For some of those professions that did not mean much of a change because they already had a lot of those elements in place, but for some of the other professions, some smaller groups, it meant a radical change in what they were doing and a significant increase in the resourcing they would need to be able to do that work. We are talking about professions with a couple of hundred members, versus professions with thousands of members. Obviously the larger ones would have had infrastructures in place, they would have had some data in place and some systems in place, and certainly we did in medicine, whereas in the smaller professions that did not exist but they all had to be set up onto the same system across the whole of that range of activity.

The task that was undertaken was truly enormous. We worked very closely with Canada, with North America in our areas, and they cannot believe that Australia was able to achieve this across all of those professions. In one profession alone across all the jurisdictions would have been a challenge, but to do it with all 10 of them that is a really significant development. There are a lot of things that have rolled out from there that we have worked closely with in terms of, in our case, the development of standards and development of processes in helping to work towards the reassignment procedures that were put in place. All of that had to be worked out de novo because there was no precedent for any of this before in Australia. We have worked pretty closely in that area.

Clearly there are areas that continue to be improved. We have viewed this process as being a three to five-year project at the very minimum and possibly even slightly longer to get fully bedded in. The example we give is that between 1992 and 2000, or an eight-year period, the board has had to come to terms in Australia working together under the mutual recognition arrangements. It was only around about the end of that eight-year period that we really started to see consistency across all of them in terms of how they were handling some aspects of the registration. Here we have a much more complex system with a lot more players involved with very different priorities and different structures having to come to terms very quickly in terms of a completely new system. If they can do it in three to five years I think that will be quite an achievement.

The CHAIR—Thank you. Ms Walters, would you like to say anything? No. Could you identify those small groups that you said had to undertake the radical change?

Mr FRANK—Well, I think the smaller professional groups—the chiros, osteos, some of those guys—will not have had the systems in place that, say, for example, pharmacy, physio, dentistry and medicine would have had, but they all have to operate against the same sets of basic criteria. They have to satisfy the same performance indicators as we all do. They have to be brought up to speed pretty quickly in order to be on the same playing field as everyone else.

The CHAIR—To your knowledge do you think that has been resolved for them?

Ms WALTERS—Yes, I think there have been good processes working with AHPRA and with the national boards and the accreditation councils to work towards a common understanding of requirements. We developed jointly a set of criteria and domains for assessment of the performance of all the accreditation councils. That was done very much as a collaborative piece of work, and last year the performance of each council was assessed against those domains through the process for reassignment of the accreditation functions. The fact that we managed to complete that process starting in June last year and finishing by and large by the end of 2012 I think is a demonstration that that has been quite successful.

The CHAIR—Thank you. In your submission you expressed concerns over the resourcing of AHPRA and its reliance on registration fees to cover both registration and accreditation activities. Could you elaborate on those concerns a little bit more for the committee.

Mr FRANK—Basically the resources that came into AHPRA started with some seeding funds upfront that were intended to assist in the development of IT infrastructures and related activities. But the basic operating costs that came were essentially the resources that were available to each of those professional bodies around Australia at the time. If you consider that many of them did not operate with the level of precision or the level of detail, for example, the very broad consultation processes that are in place now for any changes that go through, any standards, developments or whatever, they did not exist in those bodies. The resource base that was available was designed around activities that were somewhat simpler than the materials and the activities that the bodies had to perform under the National Registration Scheme.

Already the resource base that was coming in was, you might say, fairly thin on the ground. Most of these bodies were not flush with resources. A lot of them worked on pro bono support and input from various people that are working with them. They were not heavily resourced and they certainly were not resourced to meet a specification of the complexity that came out of the National Registration Scheme. That was the resource base they started with. We made a crude estimate at the time that the resourcing of this national system to build all the infrastructure you would need, to set up all the offices that you would need, to set up all the data systems that you need and then to cleanse all that data, get it up and running, would probably be two or three times the cost of registration at that time and that was a crude estimate we did based on our experience with mutual recognition. I do not have the exact details of what it took but I think the original operating costs were around about $90-odd million, and they are about $101 million now in terms of what they are doing.

For the scale of change that was put through, that is a fairly light-on resource base to start with. Our concern was—because there is no cross-subsidy between any of the professions—it meant that some of these activities were probably being funded at the thinner end of the scale. They were not flush with money, they were not funded in a very kind of generous way. That meant that some activities were perhaps a little less effectively funded. In our case we think that is in the accreditation area, understandably, because the prime responsibility from 1 July 2010 was to get people legally registered so they can practise in their particular professions and continue to do so. Clearly the emphasis would have been on registration but not so much on the accreditation side of the process.

The CHAIR—Thank you. Ms Hartland.

Ms HARTLAND—How do you feel the system is working now considering you have talked a little bit about the initial problems. Do you see that it is working now? Are there ongoing problems? Are there still things that need to be improved?

Mr FRANK—Can I take the last question first. Any system can be improved. I imagine if we had this meeting again in five years time we would be looking at a very different national registration system to the one we have now because I think it will continue to evolve. We had some difficulties to start with and that is largely because people were working, in a sense, in new territory. We did not have anything like this operating before. It was a really interesting system because unlike mutual recognition which was national legislation, this has been based on a set of state acts that empower the process to operate. It is a national system but not a federally legislated process. That has some ramifications in terms of how it operates. I think the first year and a half was, you might say, a feeling-out period between organisations like the Australian Medical Council and the Medical Board of Australia and AHPRA because while we knew the players—

certainly we knew the Medical Board players reasonably well because some of them had been on the state boards previously and had served on the AMC—when they came into this new model the constraints that are imposed by the law, not simply by process but by the law itself, meant that we had to find new ways of communicating and new ways of dealing with things.

One of the problems for us, for example, is that the accreditation process that we operated for medical schools was in most cases legislated under the state acts. For the specialist colleges it was a voluntary process. The process was largely a collegiate process. It was seen as a collegiate process for quality improvement as well as quality assurance. Under the National Law the reporting requirements are much more formalised. That has changed the relationship slightly, both in terms of how we operate with the bodies that are being accredited but also how we report to the medical board. We have taken that time to find out how can that best be done, what information do they really need to have and can we provide that information. I think Theanne Walters can speak more to this.

Over a period of time I think we have started to understand the language of both organisations and that has now moved forward. It took us, for example, nearly two years to negotiate the funding agreement between AHPRA and our council and the other councils as well. A lot of that went around understanding the requirements for intellectual property and various other associated issues, but after two years we managed to resolve those and I think now the relationships are much smoother and the agreements will move on much more smoothly than they have in the past.

Mrs PETROVICH—Thank you very much for your submission tonight. In the area I represent there are many overseas doctors in rural areas. One of the areas of interest was that evidence to the committee suggests limited registration of overseas trained doctors are not being managed properly under AHPRA. Evidence suggests that a number of those have increased with the change to the national scheme and that the supervising GPs are supervising too many LROTDs. Can you comment on those concerns and outline both the AMC's and AHPRA's involvement in supervising and training untrained doctors in general practice?

Mr FRANK—The issue of supervision I think is always a difficult one. People in limited registration are not legally qualified to practise without oversight, so they have to have some form of oversight, but it is also true to say that there is a significant variation in the standard of people that have limited registration. They may range from people who are freshly out of a medical school in an overseas country and not familiar with Australian health practice who need very close supervision and, in theory, should not be out in general practice positions, to people who have had extensive experience in general practice, albeit that they are not fully qualified as specialist general practitioners. There is a wide range of people in that area.

We have been working very closely with the national board since its establishment to look at ways in which the supervision provisions can be clarified and better documented. We have also been working with them in ways in which we could streamline some of the processes to get qualified, overseas trained doctors into limited registration and into the workplace. For example, one of the most powerful pathways we have at the moment for IMGs coming into Australia is a thing called a competent authority pathway. It is a process that was established originally in 2006-2007 to fast-track international medical graduates who had already passed examinations that were comparable to the Australian Medical Council exam, and also some other categories of people who had been through an assessment process that we deemed to be comparable. That was largely people out of Ireland, the UK, and then various countries that had passed the UK exams, the Canadian exams, the American exams and so forth.

There are about 1,500 people a year applying in that category and about 600 or 700 people a year completing the process. These are highly-trained overseas trained doctors and many of them are starting to move out into those general practice areas and into hospital based positions in rural areas as well. We have worked to streamline that process and hopefully by the end of the year that pathway for those people will be much faster than it is now and cleaner than it is now. As far as training is concerned, we are not a training authority but we do know that bridging training and orientation training for IMGs is really important and should be developed. One of the pathways we have developed is a thing called a workplace based assessment pathway of which there are now two major ones in Victoria—one run through Ballarat in that area, and the other one is run through Monash Health, I think, here in Melbourne. What that basically does is it takes IMGs with limited registration, puts them in a hospital setting and then assesses them in that setting. That process is now turning

out lots of people who are very well trained and competent to practise. They are some of the initiatives but there is still a lot more that has to be done in that area.

Mrs PEULICH—Today there was an Auditor-General's report tabled here showing that the compliance of doctors, particularly in infection control practices, was a little below the national standard and certainly below their nursing counterparts. To go to the question of professional development, how do practitioners provide evidence of continued PD and is that system adequate? If not, how could it be improved?

Prof. MORTIMER—I think there are two answers to that question. One is that within hospitals there are clinical governance processes which all practitioners have to comply with, but the specialty colleges also have continuing professional development programs which we assess as part of the accreditation process and each fellow or trainee of those colleges have to comply with those continuing professional development processes. But getting down to things like washing hands that is an in-hospital issue, and all health care practitioners need to wash their hands.

Mrs PEULICH—Including doctors.

Prof. MORTIMER—Even doctors.

Mr FRANK—There are other initiatives like the Safety and Quality Commission who is working actively in that area and assists in accrediting individual practices to deal with those sorts of issues, and there is a lot of work that has been pushed out from that group across all of the health professions, not just in medicine.

Prof. MORTIMER—It is a landscape populated by quite a lot of organisations and it is sometimes confusing.

Ms MIKAKOS—Just in relation to professional development—this is sort of following on from the previous question—if you could explain the system. Is there a professional development system acquiring points on a lawyer, the legal profession? Is there a points system where you acquire certain points over a period of a year—and I am thinking in particular of the radical reforms that will be coming in the next few years with the National Disability Insurance Scheme, for paediatrics, for example, who work with children with disabilities, and being able to guide parents and being able to advise them on the services and programs that are available to them that could assist their child. There are services in place now but under the NDIS there will be a whole range of different services. What steps can the profession take through its professional development to ensure that the profession is ready for a change, like the NDIS, for example, or other medical changes or I guess systemic changes. They are not necessarily medical breakthroughs but they are, I guess, the system, the parameters in which the medical profession works.

Prof. MORTIMER—The very essence of medical practice is change. I graduated close to 50 years ago and there are lots of things that were not invented then—CT scans, MRI scans, nuclear medicine, immunology, cell biology, molecular biology, genetics. I have had to learn all that stuff and I think the whole system of medical training and postgraduate training is designed to equip people to continue to learn. I think as these new things come along they will be learnt.

Ms MIKAKOS—But can you explain, is there a points system?

Prof. MORTIMER—There is a points system in most of the specialties. Certainly in my own college, the College of Physicians, there is quite a sophisticated online system where you put in your activities and accumulate points, and at the end of the year there is a significant collection and a fixed percentage of people are audited to make sure that they are not fuzzing the system.

Mr FRANK—Perhaps it is worth mentioning though that it is only since the National Registration Scheme came into being, so from July 2010, that we have consistent national policies around CPD and around recency practice which existed in various forms in different states around Australia but were not uniform. They have now started to come in. Only a couple of weeks ago, or just fairly recently, the debate has now started at re-validation which is a much more formalised process to ensure that people's skills are maintained

and there is evidence of that. Prior to 2010, to get that across the country you would have had to synchronise eight state and territory boards operating under very different systems. Now at least there is one body that can move that forward which I think is a very important development.

Prof. MORTIMER—To expand a little bit, the colleges have five or six different sections of continued professional development. You have to be active in each of those areas.

Ms MIKAKOS—Do you see areas that could be improved in terms of how the system operates now, and do the courses that are offered cover other issues other than, as I said, medical developments?

Prof. MORTIMER—Yes.

Ms MIKAKOS—Would it cover things like cultural awareness issues, for example, or as I said systemic issues relating to government reforms such as NDIS?

Prof. MORTIMER—Yes, they do. But a large part of continued professional development is self-directed. It is for someone to reflect on their own practice and say, 'This is an area I really need to get up to speed with,' and most colleges have that as part of their assessment process.

Ms MIKAKOS—Can you suggest any room for improvement or is there any need for changes?

Prof. MORTIMER—I think all of the colleges—and Theanne will be right across this—are continually developing their CPD programs. It is not an education process that is delivered like college and it is not all courses. There are many ways of doing it. You can do it by reading, you can do it by going to courses, you can do it by doing research, publishing a paper, a practice audit. For instance, in my own college you can get somebody to come in and spend two or three days looking at how you practise. That will serve as your year's continued professional development.

Mr O'BRIEN—Just following on from the question in relation to overseas trained doctors, in Western Victoria there are still large issues of no doctors or difficulties in attracting and retaining any doctors in certain professions and there have been various programs, some of which precede the National Registration Scheme, but which of these are working in relation to the registration issue? There have been problems when doctors have gone out, they have then picked up their points and then travelled, they have not been retained there. There is a thought that we should be training nurses into other—people have established a medical practice of some sort in a rural area, and there are specialty issues of what sort of procedures GPs can operate et cetera and what sort of risks that are associated particularly around obstetrics, I know. Where do you think we can start to get some real improvements in this area and what is the role of the national body, or your body—

Prof. MORTIMER—Are we talking about overseas trained doctors or Australian doctors?

Mr O'BRIEN—Well, attracting any doctors in some instances.

Prof. MORTIMER—Yes.

Mr O'BRIEN—Obviously attracting doctors from the region to be trained up has been a problem. If they get trained in a medical course they often want to work in the cities. When they do paediatrics they have to work in the Royal Children's Hospital. You have a retention problem of doctors even coming to areas, but you also have public safety issues in terms of what procedures can take place in regional areas, particularly obstetrics. We have higher standards of expectations of survival rates so no bush nursing—

The CHAIR—There are excellent programs in place in rural Victoria.

Mr O'BRIEN—I know. I am wondering what your evidence is on where the registration body has gone, particularly with your training role in this type of area.

Prof. MORTIMER—There is a very strong move to expand training outside of major metropolitan

areas and that has happened in the last few years. That has been done partly also to deal with this huge increase in numbers of medical graduates. But just about every medical student now spends some time in a rural clinical school. There is evidence that medical schools set up in rural areas tend to keep their doctors in that general area. James Cook, for instance, in Townsville is a very good example of that. Recruiting people from a rural background is helpful. This is a worldwide issue, it is not just in Australia that it is happening.

Mr O'BRIEN—Could you elaborate on that?

Prof. MORTIMER—In parts of the United States, parts of Canada, even parts of the United Kingdom there is difficulty getting people to move to rural areas. It is a very complex issue.

Mr O'BRIEN—Particularly around the centralisation of specialties which is occurring. If people want to advance their career, it seems, you have to move to the larger—

Prof. MORTIMER—Well, I think that is changing and I think we will see in the next few years entire training programs done in rural and regional Australia. Certainly many of the colleges are moving to that.

Ms WALTERS—One of the things that we are doing now that there is a national medical board is we are looking at an internal system for national standards and a framework for intern training. The Australian Medical Council, on behalf of the medical board, is then developing standards and processes. One of the aims in that is to make the system more flexible to open up the possibility for internships to be done in different ranges rather than just metropolitan hospitals, and in particular to open up the possibility for more training in rural general practices, intern training positions in rural general practices. I think there are a couple of states now that have that as part of their intern training.

Mr O'BRIEN—We have facilities in Ballarat too. I am just wondering where the regulatory environment is in this space. Anyway I have had some answers which I appreciate.

Mr FRANK—As Professor Mortimer was saying, the US grapples with it, Canada grapples with it and other countries grapple with it as well. The Canadian one is the one we know reasonably well because we have done joint work with the Medical Council of Canada over a number of years and they have what they call MTV, which is Montreal, Toronto and Vancouver. Everyone wants to go there, no-one wants to go into the central part of Canada. The maritimes on the eastern seaboard have the same problem. They have the same area of need type issues that we see in Australia. One of the problems you mention, the specialisation and the difficulties in that area, is that unless you have centres that can provide these kind of services to maintain the skill levels in those fields, it is going to be very difficult to maintain those services in those areas. That is always going to be a bit of a challenge. I think to expect a regulatory process to deal with your workforce distribution issues is maybe expecting too much of the regulatory process per se. As long as it does not have barriers in there to prevent people from being able to work in certain environments, that is about all you are going to be able to expect them to do. We are talking about management of health care services as much as anything else. I do not think the regulators can deal with that.

Mr O'BRIEN—With that barrier and the regulation here is again protection of public safety, what procedures—

Mr FRANK—That is right. Certainly we know, for example, that we at least have consistent requirements now across the country for supervision, for monitoring and for reporting. As I said, it is a work in progress, it is still early days for this, but at least it is a single model which we did not have before. I think there is a possibility that some of these initiatives will help in the end but they are not going to solve the problem. I mentioned earlier that we tried to develop the workplace based assessment model. We know in Launceston they had four area of need positions in the Launceston Hospital that they could not fill, they could not attract anybody. Since we have rolled out workplace based assessment, they have not only been able to attract about 20 applicants for each of those four positions but of the 18 candidates put through already, 11 of them have remained in the area, and that is without any additional cost being put in, that is simply by a different type of assessment process. That has nothing to do with the regulatory process, the regulatory process allows us to do that, but there is no barrier from the regulatory process to do that. There are initiatives

that can be developed but they are not necessarily initiatives that will come out of the regulation per se.

The regulation systems that we have now, at least the national ones, will allow us to do a lot more in terms of rural services than we were ever able to do before—the rural locum, the Royal Flying Doctor Service, telemedicine services—none of which we could do effectively prior to 2010, because the practitioner had to be registered in a state in which the patient was located in every case under the state laws. Now they only have to be registered once and they can provide those services everywhere. That is a significant breakthrough.

The CHAIR—On that point, to take you back to your initial comments I think where you said you worked closely with the Commonwealth and the federal minister, and in relation to Mr O'Brien's question and the answer you have given, you have these barriers in place but in your view is there some accountability for independent jurisdiction? We have this national registration which allows for ease of mobility and other systemic efficiencies for the registration process et cetera, but what about accountability in terms of those individual jurisdictions? Do you have a view on that and how the overarching scheme operates or does not operate?

Mr FRANK—In the case of medicine there are still state boards of the Medical Board of Australia that will deal with individual issues at a local level. The advantage we see over the process is that now a practitioner does not have to physically appear and register in each jurisdiction in order to be able to provide those services. Equally, any action that is taken against a practitioner is uniformly applied right across the country. Again whatever action is taken in a—when I say jurisdiction, it is a national jurisdiction now with the Medical Board of Australia, but any action that is taken in a particular physical location, a state, would apply across the whole country automatically without there being any dispute or any argument about that. That provides a measure of protection that was a little bit stronger than we had. Mutual recognition improved it but this is significantly stronger.

Prof. MORTIMER—It is the jurisdictions that fund a lot of undergraduate training and postgraduate training, and there are training networks emerging in many of the jurisdictions, including Victoria. Somebody training in a specialty is moved around a wide variety of—

Mr O'BRIEN—A lot of training is still done in hospitals too. My brother is a professor and he did research at Frankston. The two are very important.

Prof. MORTIMER—Yes.

Mr O'BRIEN—But, yes, a centralisation within specialties I see as a logistic problem of specialty which is where we get our advances. I am not sure what our rural solution is but—

Mr FRANK—Well, bear in mind again—because, you know, there is a provision where you can provide services remotely. One of the things we have now seen is that it is possible to deliver training and even deliver some health services remotely in ways that we were not able to before. We have already mentioned one, the James Cook initiative. The other very powerful initiative that is going on, and it has been going on for a while now, is Flinders Medical School with its program in the Riverland. That is a very powerful process. They are now also looking at Darwin. We are now able to deliver education and training through remote programs, but the most important thing is we can deliver services now more efficiently than we were able to do before.

Mrs PETROVICH—Just following on quickly from Mr O'Brien's point, it is something that I come across in rural and regional areas often, and I think it is not about the regulation but how do we better support our supervising rural practitioners. There are a range of complexities around that. Is it acknowledged by AHPRA through an accreditation process or support in any way?

Mr FRANK—It depends on the limitations of the legislation. There is no legislative power for AHPRA to be involved in that space. If the person is a registered practitioner with the appropriate category of registration—and I am assuming they either have a specialty general practice registration or general registration—that is the extent of their capacity I think to become involved in that area. That is not to say that there are other players who perhaps should be more actively involved in that sort of role. I do not know if the

regulatory body has the kind of legal authority to go there and that is a bit of an issue.

The CHAIR—I do not believe there are any further questions so on behalf of the committee can I thank you very much for attending this evening and for providing the evidence that you have. It has been most helpful.

Prof. MORTIMER—Thank you.

Mr FRANK—Thank you.

Witnesses withdrew.

Hearing suspended.