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

LEGAL AND SOCIAL ISSUES LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Brisbane—22 November 2013

Members

Ms G. Crozier
Mrs I. Peulich
Mr D. O'Brien
Ms A. Millar
Ms J. Mikakos

Chair: Ms G. Crozier

Staff

Senior Secretary: Richard Willis

Witnesses

Australian Medical Association, Queensland:

Dr C. Rowan, President; and

Ms E. Cotterill, Senior Policy Officer.

The CHAIR—Good morning. I declare open the Legal and Social Issues Legislation Committee public hearing in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency. We were pleased to conduct the hearings today in Brisbane with a particular focus on the health complaint system, recent developments in this state to create a Health Ombudsman and matters related to the national registration and accreditation scheme for health practitioners. I welcome Dr Christian Rowan, president of AMA Queensland and Ms Emily Cotterill, senior policy officer. Thank you both very much for your time and being with us this morning.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Victorian Constitution Act 1975 and further subject to the provisions of the Victorian Parliament Legislative Council Standing Orders, the Parliament of Victoria's Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation of Australian states and territories. All evidence is being recorded and you will be provided with a proof version of the transcript within the next week.

I think, as you are aware, we are looking into AHPRA and the functions of AHPRA in particular areas in relation to. We are very interested to get some thoughts from your perspective. I am just wondering, do you have statement that you would like to make for us or give us a bit of an overview from your perspective?

Dr ROWAN—Sure.

The CHAIR—That would be terrific, and then we might ask questions.

Dr ROWAN—Okay.

The CHAIR—Thanks very much.

Dr ROWAN—Well, thank you for the opportunity for AMA Queensland to speak here with the Victorian Parliamentary Inquiry into AHPRA. AMA Queensland is the state's peak medical body representing over 6,000 member doctors and students. Our members interested are to provide the best possible care to the public whilst participating in a fair, efficient and transparent complaints management system that is accountable to the community. AMA Queensland recognises the important contribution that an effective health complaints management system can have in improving the health system and ensuring that future patients can safely and reliably enjoy a positive health are experience. Our association is committed to working with government at all levels and the community to improve the safety and quality of our system.

Our members interests are to provide the best possible care to the public whilst participating in a fair, efficient and transparent complaints management system that is accountable to the community. Any complaints management system should ensure the required clinical and professional standards are maintained, and are subject to ongoing improvements in medicine and health care. To be effective in gaining public and clinician confidence in the Queensland Health system and restoring a culture of openness and transparency, the health complaints model needs to strike an appropriate balance between patient safety and the recognition of the inherent risk involved when a patient requires medical interventional treatment. The independence and perceived independence of the Health Ombudsman which is going to be implemented in Queensland carrying out his or her role will be paramount to achieving that confidence.

From a personal perspective, I am the current president of AMA Queensland. I am registered with AHPRA as both a medical administrator, an addiction specialist and also in the discipline of general practice. I am the deputy chief medical officer for UnitingCare Health and the director of medical services at St Andrew's War Memorial Hospital and I have had significant experience in primary, secondary and tertiary care both in rural and regional Queensland, as well as in urban tertiary hospital environments as well.

The CHAIR—Very well qualified, I would think. Ms Cotterill, would you like to make any comments to the committee?

Ms COTTERILL—Nothing further to add.

The CHAIR—Okay. Thank you very much for that and thank you very much for the overview of what AMA Queensland undertakes. I am just wondering, could you outline to us the evidence that AMA Queensland provided to the Health and Community Services Committee Inquiry into the Ombudsman's Bill?

Dr ROWAN—AMA Queensland provided a submission that the current bill at that stage before it had got through to parliament had significant flaws and the association had significant concerns about the bill's impact on good clinical practice. The key issues of concern for AMA Queensland were that the bill did not ensure adequate independence from government, the bill did not ensure that experienced clinical and ethical advice would be sought from health professionals before decisions were made, the bill did not ensure that complaints would be dealt in a timely manner and that the bill potentially detracted from the national registration scheme in that there was going to be a loss of uniformity across all of the jurisdictions.

Specifically in relation to independence, the spirit of a true ombudsman, in our view, was that the ombudsman should report directly to parliament as opposed to being hired and fired by, and appointed by the health minister, so AMA Queensland submitted that the bill should be amended to provide for a Health Ombudsman who is accountable to parliament with similar arrangements to that of the state ombudsman.

In relation to clinical input, we had a significant concern that there was inadequacy in relation to explicit clinician involvement in providing advice to ensure that the level of expertise and clinical input necessary to make robust, fair and transparent decisions, that was not explicitly within the legislation. We were concerned in relation to the problems as far as we saw them in relation to adequate resourcing for the Health Ombudsman to perform their functions and there was a lack of clarity around that. In relation to the timeliness of processing of matters, there had been significant delays in QCAT, the Queensland Civil Administration Tribunal. AMA Queensland was also concerned about the unilateral ability of the Health Ombudsman to exercise power to immediately take action without sufficient checks and balances to ensure that the system upholds the basic principles of natural justice and they were our main concerns which we tabled with the committee at that stage and also with the government prior to that.

Mrs PEULICH—Just in terms of machinery, so no decisions of the Health Ombudsman could be appealed elsewhere? Was there an appeal process within that bill?

Dr ROWAN—There is an appeals process but in relation to, I guess, the ability of the Health Ombudsman to take immediate action without actually having clinical input into that advice, we thought in the best interests of not only protecting the ombudsman, the public, the government and to balance the rights of the practitioner, that having that explicitly within the legislation would have been wise and prudent.

The CHAIR—You mentioned there you had concerns about the ability to conduct the inquiries in a timely manner. A lot of the evidence we have heard in Victoria is exactly that issue, that AHPRA is unable to conduct inquiries in a timely manner. I thought that I read in the bill that there was a time frame on this, that there was 12 months to report in relation to a particular issue and then they would have three monthly follow-ups and then, if it proceeded, it would be reported back to the parliament. Am I correct in assuming that?

Ms COTTERILL—Yes.

The CHAIR—Could you comment on why that is not a sufficient process?

Dr ROWAN—Well, again, from our perspective, there was a lot of lack of detail, I guess, as to how that was going to be implemented and we were told that some of those matters would be within the regulations, but we have not seen the content of those regulations, and we felt that needed to be explicitly in the legislation.

Ms COTTERILL—In addition to that, there are currently timelines around the medical board and Health Quality and Complaints Commission's processes, and they are not currently met on time. Our main concern in relation to time limits was that decisions made by the Health Ombudsman, especially immediate decisions, can only be appealed to the Queensland Civil and Administrative Tribunal and the waiting times for

that are currently very long, as far as I can ascertain.

Dr ROWAN—They were our concerns around natural justice and procedural fairness, given the operations of QCAT at the moment and the significant delays in there that once a decision is taken and through the appeal process, it is through that, that it may take a significant period of time for that to be processed through that entity.

The CHAIR—We have a similar system, obviously, in Victoria, known as VCAT, and there are certain delays in relation to issues going through that tribunal as well. Why don't you think that is a normal process for appeal?

Dr ROWAN—Well, in the sense that if a decision is taken without clinical input and let's say the decision is subsequently shown to be incorrect, that the check and balance was really about actually having the mandatory clinician involvement up front before that decision is taken, and if the Health Ombudsman is a legal practitioner who makes a decision in good faith but without the necessary clinical input at that stage, there is the possibility that a practitioner could be suspended for a significant period of time with loss of income and professional reputation consequences, and then subsequently that matter is then overturned through other appeal mechanisms, but it may be up to 12 months before that is determined. It really comes back to the concern about the mandatory involvement of clinical knowledge and expertise in the decision-making processes of the Health Ombudsman, and we would have liked to have seen that explicitly within the legislation right up front, that needed to occur given the skill set that the Health Ombudsman may or may not have, or health woman ombudsman.

The CHAIR—I will move to other members in a moment. I have just got one final question. Do you believe the minister should have some oversight and accountability for what is conducted in relation to the Queensland Health services?

Dr ROWAN—We would believe that for a Health Ombudsman in the spirit of true public governance that they should be reporting directly to parliament and then being oversighted by, you know, a parliamentary committee would be appropriate. We certainly do accept, I guess, that the health minister in relation to discharging his functions as a minister of the Crown may need from time to time to be briefed and provided information on specific matters, but in relation to being able to hire and fire the Health Ombudsman and direct the Health Ombudsman to undertake certain investigations, that there can be a perceived and/or actual conflict of interest in relation to that.

Mrs PEULICH—Sorry, just on the machinery, elevating a Health Ombudsman to the status of an ombudsman, I have got a few problems with that, but I certainly acknowledge and am concerned about the issues that you raised, especially in terms of having decisions informed adequately by clinical practice and also the delays in terms of appeals and so forth. Our other ombudsman, such as, say, the telecommunications one and sort of other specialist ombudsman, do they all report directly to parliament or do they report to the minister concerned?

Dr ROWAN—Our current state ombudsman reports directly to parliament.

Mrs PEULICH—Yes, I understand that, and that is an overarching position and they have got some substantial powers in terms of the review of administrative decisions.

The CHAIR—Specific ombudsman, though, you are talking about.

Mrs PEULICH—The specific ombudsman, do they all report directly to parliament, or would that actually be in a sense also undermining the overarching ombudsman position?

Dr ROWAN—I think the best way of answering that is to consider the matters going back to 2005 when we had the events of Bundaberg at that stage and the clinical governance of those, and the Morris and Davies Inquiries and forced to review the establishment of the Health Quality and Complaints Commission under the Health Quality and Complaints Commission Act 2006, and the HQCC commissioner at that stage, and the entity of the Health Quality and Complaints Commission, was very independent and oversighted by a

parliamentary committee.

The CHAIR—That was a specific purpose inquiry. Correct?

Dr ROWAN—The establishment of the HQCC?

The CHAIR—Yes.

Dr ROWAN—Well, the establishment of the Health Quality and Complaints Commission have two functions around health complaints management and also the setting of standards, and in a stand-alone entity under the Health Quality and Complaints Commission Act was very independent of government.

The CHAIR—I understand what you are saying.

ms COTTERILL—But it has an ongoing function.

The CHAIR—It has an ongoing function.

ms COTTERILL—It is a permanent body, but it is been wound up now with the introduction of—

Dr ROWAN—So with the introduction of the Health Ombudsman the Health Quality and Complaints Commission is completely disappearing, and so the introduction of the Health Ombudsman is to completely replace that independent entity.

Mrs PEULICH—Sorry, just to understand the machinery and what you guys think would work, was there any other way that you actually address all of your other concerns without necessarily creating the direct reporting to parliament? I understand it needs to be at an arm's length, but at the same time the appropriate minister appointed by a Governor in Council has to take responsibility for matters with his portfolio. To make it more robust, if there was mandatory inclusion of independent clinical advice, would that go to some way of appeasing or resolving your issues?

Dr ROWAN—Well, if it is in the context of there is no medical board of substance in Queensland now, so with the absence of having, you know, an independent medical board with, now, I guess the move away from an independent Health Quality and Complaints Commission and an independent commissioner who is reporting to parliament from that perspective, the changes where we will be not jurisdictionally aligned with the other jurisdictions in relation to the AHPRA, I think once we put all of that together plus the concerns in relation to not having a mandatory involvement of commissions in some of these complex and decision-making processes, the long delays in QCAT and the risk to natural justice and perceived procedural fairness, and also some of the concerns around what we would regard as some of the Draconian name and shame elements, that may send a signal to impaired practitioners who have got physical or mental disorders not to seek help.

I think if we put that into that sort of holistic kind of box with all of those elements, that is why we have concerns across the board. Just the independent reporting to parliament in and of itself will still not rectify all of those other elements, particularly the clinical involvement that would need to occur. Just because you had a person with a legal training background as the new Health Ombudsman, they still require that clinical input, and that should have been explicitly in the legislation, in our view.

The CHAIR—Does clause 172 not give some comfort in relation to what you are saying, that it provides that, 'The minister may ask a national board or the national agency for any information related to its functions concerning the health performance and conduct of registered health practitioners in Queensland.' Doesn't that—in relation to what you have just said to Mrs Peulich about concerns with various practitioners—cover those particular concerns even though you do not have a state based medical board per se?

Ms COTTERILL—I am sorry, I am just trying to understand your question. The health minister being able to request information directly from the Health Ombudsman—

The CHAIR—Well, no, it is saying that he can go further than that. He can go to the national agency for any information related to its functions concerning the health performance and conduct of registered health practitioners in Queensland, so it is not solely confined to Queensland, but they can go to the national body if need be. What I am asking is: even though you do not have a specific medical board per se here in this state, if there was a need to go further at a national level does that clause then—is that sufficient for what you are asking?

Dr ROWAN—Well, I can only answer that as a medical administrator, I guess, of what happens in the practical way, and I have had instances where I have had a practitioner that is had to be reported under the mandatory provisions in relation to suspected drug use and the discharging of their duties. Certainly—

The CHAIR—Sorry to cut in there. Do you have a doctor's health program operating?

Dr ROWAN—A doctor's health advisory service.

Ms COTTERILL—We do not have an equivalent doctor's health program there. The Victorian one was set up by the Victorian medical board and it was not replicated in other states. We have a health advisory service—

Dr ROWAN—Advisory service.

Ms COTTERILL—Which is a voluntary run program, and the medical board's currently working to increase the funding to that body so that it can provide more health services.

The CHAIR—Sorry to interrupt you. Thank you for that clarification.

Dr ROWAN—No problem. From an operational perspective working as a medical administrator and having those circumstances, when I have contacted AHPRA to understand the progress of those matters, they will indicate, 'Well, this is a matter between the registrant and AHPRA, and you as an administrator are not entitled to have information in relation to the progress of those matters,' which makes it extremely difficult for a health administrator when you have a practitioner who you have actually reported, and in relation to trying to protect patient safety and look after their welfare—and they also will state, 'We offer no comment onto the competence or capability of the practitioner,' and that makes it extremely difficult at that level.

I am coming back to answering that, that if you then—whilst all of that might be happening in Queensland from that perspective—can you then go to AHPRA and get the information that you actually need? Well, I would suspect that the answer is no.

Mrs PEULICH—A minister may be able to do so, not necessarily you.

Dr ROWAN—And that is, I guess, coming down to the legal—

Mrs PEULICH—And I guess I can understand—

Dr ROWAN—And I would not be an expert on—

Mrs PEULICH—Why that sort of information may not be forthcoming so far as if we are talking about due process and natural justice, it would perhaps be a breach of those to provide sort of supplementary whilst those processes are commenced.

The CHAIR—Thank you. Ms Mikakos.

Ms MIKAKOS—Thank you, Chair. I know we have been talking about the legislation itself, but I guess I want to go to the context and why the government perhaps may have decided to go down this path. Just to give us a little bit more history to this, and you referred before to some of this, there are some quite well publicised cases here in Queensland in relation to failures of the health complaint system. Can you

comment on those and perhaps the different approaches that have been attempted to address some of those in the past just to give us a bit of that historical context?

Dr ROWAN—Certainly, AMA Queensland accepts that the health complaints management system in Queensland was still not working, and there were a number of instances where that was clearly identified in the public domain and also through reviews and various reports that were handed down, to name two, the Chesterman and Forrester, and Hunter Reports, yes. Clearly, the coordination and the liaison between various agencies, whether that be the Health Quality and Complaints Commission, the medical board, AHPRA, the Coroner, it was clear from the conclusions within some of those reports that the timeliness and also the decision making process were given fairly comparable sets of circumstances.

In two different cases there were different conclusions reached, that it was hard to justify that the system had been working well so change of some description was needed, but again the process of how that change was implemented, the consultation that was undertaken and then the final model that was put forward and is progressing, in our view, was still deficient for the reasons that we have outlined.

Ms MIKAKOS—Did you want to refer specifically to any of the recommendations in those reports that you refer to? Were there things in there that you were in favour of?

Dr ROWAN—Certainly, in relation to resourcing, it was clear that, you know, the medical board particularly probably did not have the sufficient resourcing to undertake some of the functions that it was asked to undertake, and there was a growing number of cases that they had to look at and were not able to discharge their functions in a timely way related to resourcing. Certainly, there were matters that needed to be re-examined, and that process has been occurring, from our understanding, given the interim for people who are the nominal medical board people who are actually going through those matters.

The case for change, clearly the system was not working and there needed to be some form of chance, but we believed that the model that is now being put forward has got risks still associated with it and that it may not be able to deliver what is required if it is not adequately resourced and if there is any perceived risk of a lack of transparency, natural justice and procedural fairness to all involved.

Ms MIKAKOS—Thank you.

The CHAIR—Thank you. Mr O'Brien.

Mr O'BRIEN—Thank you, Chair. Following on from Ms Mikakos, you identified the sort of tension between the patient's safety and inherent risk at the start. Would you also accept, particularly in relation to rural areas, there is also the question of allocation of medical expertise and appropriate supervision both within the medical profession and also for the regulatory agencies as part of the thing that is got to be worked out, by which you could have no rural hospitals, no rural medicine but you would then be declining a service, or you could have some level of trust and supervision, that is the heart of the issue.

Dr ROWAN—Well, that was one of our concerns from a practical perspective. If you had a regional surgeon or a regional proceduralist, as an example, and let's say they were the only person in that particular specialty and there was a concern raised in relation to their performance, and let's say immediate action was taken to suspend their registration because it was around technical performance, you know, the types of surgery that they do, that without adequate thought and due consideration you could then have a service collapse. If we pick colorectal surgeon, for example, let's say there was concerns in relation to how they did their colectomies, the removal of the bowel, that might be referred to the Health Ombudsman, who, without the clinical skill, knowledge and expertise or access to that, might make the immediate decision to suspend that person's registration, therefore, those people in that community, if he was the only practitioner, would then be without that service, and that night you would then find potentially that people may not be able to access, you know, acute services as well if there was a significant people waiting to have colonoscopies and other procedures, they would not get access to that. The reason I highlight that is because there may need to be restrictions placed on someone's scope of practice or the types of work that they do—

Mrs PEULICH—As an intermission?

Dr ROWAN—As an intermediary—

Mrs PEULICH—Intermission.

Dr ROWAN—An interim measure without actually having to suspend the man, that you actually need significant and wise knowledge and expertise from clinicians to actually advise on that, because someone may be able to continue to practice as far as assessing patients from a histories perspective, perform their colonoscopies but not actually doing the surgery. It may be more wise and appropriate to keep that person in place doing that under a limited scope of practice as opposed to immediately moving that. Given Queensland is the most decentralised state in Australia and significant regional populations that those risks to those populations, the easy thing to do is always to suspends someone's registration, the harder thing to do is to actual limit their scope of practice and keep them practicing and ballot the other risks that may emerge if you do not consider that broader context. Our view as well is, given the other challenges that Queensland Health has had from administering a system and from clinical service planning, we were very concerned about those ramifications as well.

Mrs PEULICH—Further on that, would there be other measures that could be taken to broaden the toolkit that a Health Ombudsman could have?

Dr ROWAN—And so that was our view of the reason that we explicitly wanted clinician involvement in the legislation, because that would enhance the—

Mrs PEULICH—The options.

Dr ROWAN—Options for the Health Ombudsman to take when they have to consider some of these complex matters, and, again, this comes back to the Health Ombudsman could be a medical practitioner but they could easily be a legal practitioner or a retired judge.

Mrs PEULICH—Just in terms of machinery, your point about the right to notify us earlier versus the natural justice argument, is there a way that both could be met at the same time? Obviously, it is a tension.

Dr ROWAN—You have to ensure that both are met at the same time.

Mrs PEULICH—Do you have a view on that as to how that can be achieved? I mean, the interim measures that you are talking about could actually alleviate some of that tension.

Dr ROWAN—That is right, and that is the point around that, that those interim measures could actually ensure that there is due welfare considered for patient populations, so whilst balancing that action may need to be taken but it may need to be more limited action because of the other risks that could be exposed to those patients who are in that population.

Mrs PEULICH—That does not entirely address the issue of the right to notify. Do you have a view as to how the two could be met at the same time?

Ms COTTERILL—The legislation currently says that notice can be given to employers, but we would stress that there needs to be some substantiation of the claims before notice is made, and that only as much information as is necessary to protect or to guide the employer or notify in their practice.

The CHAIR—Could you just explain that a little bit more?

Ms COTTERILL—Yes.

The CHAIR—What is a substantial claim or allegation? Are you not putting patients at risk if there is any thought that some practitioner may be, you know, carrying out a procedure or doing something under the influence of drugs or whatever? I mean, we are talking about protecting the—

Ms COTTERILL—I do not mean a substantiated allegation, so a little bit of investigation has been done.

The CHAIR—It is more suspicion.

Ms COTTERILL—More suspicion, yes.

Dr ROWAN—In relation to AHPRA, and I would go back to as I am a medical administrator, it is very difficult if you are the identifier as the employer of a set of circumstances that requires no notification to AHPRA and you are managing that, that as soon as you pass that information onto AHPRA then you are completely blinded as to what is actually happening from that point on. There have been situations where we say, 'Well, in relation to**—**'

The CHAIR—It is unworkable, isn't it.

Dr ROWAN—It is unworkable, because in relation to the regulator, if you are not able to be provided back any information as to what is progressing, well then you have to make your own determination. When we have formed a reasonable view that there may be notifiable conduct and have actually notified that off from our perspective, but whilst still balancing that there may be other matters or other circumstances and we have handed it across to the regulator, to AHPRA, to investigate those matters, in the meantime we have had to make decisions to ensure patient safety and compromise any natural justice that may be applied to the practitioner because we were not able to be supplied any information back from the regulator, from AHPRA, in relation to the status of their investigations.

We have done that where we have said, 'Well, we are going to act in the interests of patient safety as the employer as opposed to waiting for a significant time delay by AHPRA,' and so under those circumstances the interests of patient safety have far outridden any natural justice elements that may be applied to the practitioner.

The CHAIR—And that is a significant issue, and we have also heard evidence similar to that from our hearings in Victoria and that is one of the major concerns. I think Mr O'Brien has a further question.

Mr O'BRIEN—Just a couple more. One of the others that I think comes into this exercise is that in certain instances there will be standards of purported procedure that will fall well below accepted medical practice, but in others there can be a debate within the profession as to what is appropriate or what is appropriate for, say, rural practice, you know, and part of the nimbleness or the way the system has to eventually work itself out, it be the national body or state body, is to be able to be responsive and consistent.

The part of the Forrester reports that we have received, or the committee into the bill, parliamentary committee, identified there was a lack of consistency and predictability of outcomes in the board's decision across notification of a similar nature, and that, to me, is particular concerning because it shows that it is not internally consistent. Could you elaborate some of those concerns, and, as a second part, if you could touch on the issue of whether they are best handled in a national body or more of a state focused body?

Dr ROWAN—Certainly, we accept that reading through the conclusions of that report that, again, there were decisions which did not seem to be in keeping with best practice, and also that there were decisions given similar sets of circumstances in two different sort of cases that there were different conclusions reached, and that was clear from the conclusions in the report. The medical colleges recognised by the Australian Medical Council are the most appropriate peer review entities to set the education and training, and ongoing continuing professional development standards in relevant areas at a national level. Obviously there are entities in the various jurisdictions which report through to those national colleges, but our view is that the medical colleges recognised at the AMC level are the most appropriate to set the professional standards. Again, from a medical practitioner perspective in relation to the code of conduct, the AMC's code of conduct and that recognised by the Medical Board of Australia is the most appropriate guiding document for setting professional standards, and ethical and professionalism perspective.

Mr O'BRIEN—You accept that, so that is where the standards are set. Then we have the play out

through the various notification procedures and the two basic options, it seems for us, as a committee to consider, or perhaps what formerly existed where you had the state-based boards and what Queensland is going back to under this bill. New South Wales also operates under a co-regulatory model, so we have been advised, but obviously the problems in Queensland make it particularly acute that it occurred and it could be occurring elsewhere as well. In that complaint management or notification procedure, do you accept that there is some advantages in having it as a state-based more localised system than AHPRA, or are you fundamentally desirous of staying within the national system?

Dr ROWAN—Well, again as a medical administrator, understanding that the actual complaint itself is part of the broader context of clinical service delivery and how you plan for that, and so when you do have these complex complaints that come in again coming back to the implications of the conclusions that may or may not occur in relation to how that complaint is managed will have an impact not only on medical workforce, clinical service delivery and clinical planning, and, again, at the very practical level, if you remove—let's say there is a complaint about an obstetrician and gynaecologist, that will have a flow-on effect, potentially, to neonatology, to paediatrics and to a whole heap of other ancillary services, and so I believe that complaints management needs to be performed very locally and that there needs to be robust mechanisms of linking that process with all of the other operational type elements that need to be considered when you are providing clinical services, whether that be in hospitals and primary care or at a population health level, and only that can be really fully appreciated in that contextual level at a local level, and so that is why there needs to be very significant input at a local jurisdictional level to—

Mr O'BRIEN—You mean in the sense of a state level and—

Dr ROWAN—State, sorry.

Mr O'BRIEN—State level, yes. Those examples are familiar to us in terms of the submissions we have received, particularly in regional areas because, yes, if you have a complaint, you will not only have an individual doctor who has the rights, but you also have the community potentially losing its service, and, yes, further thoughts about that I would very much appreciate along the lines of what you have said.

The CHAIR—Just on that, there is no Queensland medical board?

Dr ROWAN—There is an interim process of four individuals at the moment who were tasked, once the medical board was removed, there were four individuals tasked to go through the backlog of outstanding cases and also to review some of the matters which were under review, but at this stage there is a lack of clarity as to what the new model will look like into the future or what medical board—

Ms MIKAKOS—Is there intention to wind that up, is that what you are saying?

Ms COTTERILL—No.

Ms MIKAKOS—It is a transitional measure, but it still exists with a view to winding it up? Sorry, I am just trying to get—

Ms COTTERILL—I believe the medical board will stay on. It is mentioned in the legislation, but it will have a reduced role and that all complaints will go to the Health Ombudsman first to make a determination about whether they are serious enough to be dealt with by prosecution or immediate action, and if he makes the decision that they are not, then I believe that those matters will be referred to the medical board for management and ongoing—

Dr ROWAN—But the timing of the structure—

The CHAIR—That is your issue, isn't it, the timing and the structure in relation to how those complaints, when they come in, what happens. In the legislation, it talks about the assessment facilitation investigation and those issues, so that is your major concern around that process.

Dr ROWAN—That is right.

The CHAIR—Okay. Ms Millar.

Ms MILLAR—And on that, what input will your organisation seek to have into those further decisions around the medical board in the future?

Dr ROWAN—We meet regularly with not only the Department of Health but also the health minister and other government representatives to put forward our views, and we have done that throughout this entire process, and we provided a detailed submission before the bill went to parliament, and we will continue to have those conversations for what we believe is in the interest of good governance protecting patients and also what is in the interests of procedural fairness and natural justice for medical practitioners.

The CHAIR—Mr O'Brien, have you got another question?

Mr O'BRIEN—Look, I can explore**—**

The CHAIR—Well**—**

Mr O'BRIEN—I will wait.

The CHAIR—I have one in relation to the New South Wales mechanism. Have you got any comments in relation to how they operate and how you operate?

Ms COTTERILL—I have very limited comments. The only thing I can say is I have spoken to our colleagues at AMA New South Wales and they are very happy with the way they operate, and I think that has been through good operation of the system. It is not the structure of the system which has been so good but the way it is been operated and the way that it cooperates with medical practitioners, and has a very strong board of medical experts that it consults for**—**

Dr ROWAN—And it is my understanding**—**

The CHAIR—That is the difference, the board has some medical input.

Dr ROWAN—That is my understanding of how the New South Wales model works, that there is a significant involvement from a clinical input level into the complaints management system.

Mrs PEULICH—You have an advisory board, is it? No?

Ms COTTERILL—I cannot be sure.

Mrs PEULICH—I note, just researching a few of the other ombudsman, that often they do have an advisory board that may be, if you like, used to inform decision.

Dr ROWAN—Again we were assured that would be put into the operational aspects, that is the implementation process and, in fact, any Health Ombudsman, that is what they will do, but that was not sufficient for our purposes. We believe that needed to be explicitly in the legislation.

Ms COTTERILL—It goes back to**—**

The CHAIR—Isn't in the legislation to say they have the power to form a panel?

Mrs PEULICH—Yes, power, but it is not an obligation.

Dr ROWAN—Isn't an obligation. That is on that**—**

Ms COTTERILL—It comes back to resourcing as well.

Dr ROWAN—Because at this stage, I mean, even in the Health and Community Services Parliamentary Committee, when we were questioned by them in Queensland, was they are specifically around the resourcing and would it be possible if the new Health Ombudsman would be attached to the state ombudsman, and just be sort of a side entity of that, and we had significant concerns if that was to occur because the Health Complaints Commission has had at least 75 full-time equivalent staff—

Mrs PEULICH—A number of ombudsman complaints that we have in Victoria are phenomenal, so it would just clutter up the system even further.

Dr ROWAN—It was the discretionary nature within the legislation of having clinical expertise but also a lack of clarity around resourcing that made us very concerned.

The CHAIR—I understand. Mr O'Brien.

Mr O'BRIEN—Just some financial accountability and transparency issues that have been identified in Victoria, the pros we have heard from a lot of the former medical boards and practitioners, particularly, is that they are paying more fees to the AHPRA model but receiving less service, and they may or may not be tied up with this sort of bureaucracy issue and inconsistency issue, but what are your views on that in relation to Queensland, that sort of suggestion, and how will you think they will go under the new model? Will there be a reduction in fees?

Dr ROWAN—Well, certainly AMA Queensland members have provided feedback in relation to what they regard as growing fees that they are having to pay to the regulatory entity guess for ongoing registration, and with very little additional benefit, I guess, from that perspective, so we would be concerned about any further increases in registration fees that would have to be paid. Whether this implementation process will lead to that, I really could not comment on, I am not sure of how much additional finances, I guess, will be applied to individual practitioners as a consequence of putting in these arrangements.

It would be fair to say from the data that we have seen from medical defence organisations not only in Queensland but across Australia, there seems to have been a growth in the number of referrals of complaints type matters to various regulatory entities, which I suspect will lead to higher costs, whether that be indemnity costs and/or registration costs.

Mr O'BRIEN—One might think there could be an argument that the fees could come down or should come down if it was argued they were less fees and there is now a more cumbersome system, and in terms of the choice of referral, one would think you would be heading to a more simpler system, one might argue that the fees would come down, but you have not had any particular advice about where that is going to go.

Dr ROWAN—No, had no advice.

Mr O'BRIEN—Okay.

The CHAIR—Thank you. Mrs Peulich.

Mrs PEULICH—Just to further tease out the idea of having an advisory board inform the decisions of a Health Ombudsman, at the same time you do not want to neuter the ombudsman entirely, so is there a way of rating the seriousness of complaints so that an ombudsman can routinely deal with things that may be, sort of, of a lesser order and be obliged to consult an advisory board for more serious matters?

Dr ROWAN—We would imagine that triaging process will be put in operationally and there would be trigger points, presumably, within that sort of framework which would automatically require the involvement of your advisory board and, again, having that as an absolute explicit process within the legislation, we thought, would have been wise, and given that the number of matters which have made it into the public domain in relation to those types of complaints have been at that higher end, that higher sort of fidelity end, but they are the ones that we are most concerned about, and the implications and how those are actually managed.

Mr O'BRIEN—Can I just pull up on that?

The CHAIR—Yes.

Mr O'BRIEN—Just on that, how would duplication be avoided in your understanding of the new system if a complaint is forwarded to both AHPRA and the Health Ombudsman?

Dr ROWAN—Well, it is our understanding, and there is a lack of clarity, in my mind, that all matters of that nature will go to the new Health Ombudsman first—

Mr O'BRIEN—First.

Dr ROWAN—And they will all be funnelled or triaged through the Health Ombudsman, and it will be up to the Health Ombudsman how they liaise with AHPRA.

Mr O'BRIEN—Okay.

Dr ROWAN—That is my understanding.

Mrs PEULICH—The reason being, as I would imagine, that accreditation really should be a separate process from handling those complaints, if you are actually going to set up a very Bible, ethical system that stands up to**—**

Dr ROWAN—It is our understanding that a Health Ombudsman will be the first point of contact.

Mr O'BRIEN—And potentially the only—or could you have two parallel complaints going, in theory, or not?

Dr ROWAN—Well, I think the intent is that does not happen, the intent is that it will be the Health Ombudsman will be the single point of accountability, the single point of assessment triage and management, and will then be liaising with other entities as appropriate, and if that be state-based jurisdictional entities, whether it be the coroner or whether it be with national entities.

Mrs PEULICH—It is an important check and balance because I guess if a single board will stuff up there is this likelihood they will cover up.

The CHAIR—Ms Millar, have you got another**—**

Ms MILLAR—No, I think we are fine.

The CHAIR—I do not have any further questions. Thank you both very much indeed, that has been most helpful and most interesting, and we do appreciate your time. I know that you have set aside some specific time to meet with us and we really appreciate you doing so, so on behalf of the committee, can I thank you both very much indeed.

Dr ROWAN—Thank you for the opportunity.

The CHAIR—That is very helpful.

Dr ROWAN—Okay, thank you.

The CHAIR—Thank you.

Witnesses withdrew.

Hearing suspended.

PROOF VERSION ONLY

LEGAL AND SOCIAL ISSUES LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Brisbane—22 November 2013

Members

Ms G. Crozier
Mrs I. Peulich
Mr D. O'Brien
Ms A. Millar
Ms J. Mikakos

Chair: Ms G. Crozier

Staff

Senior Secretary: Richard Willis

Witnesses

Department of Health:

Dr M. Cleary, Deputy Director General;

Ms R. Welch, Director, Regulatory Instruments Unit; and

Ms J. Phillips, Executive Director, Health Systems Innovation Branch.

NECESSARY CORRECTIONS TO BE NOTIFIED TO SECRETARY OF COMMITTEE

The CHAIR—We might commence and it is a pleasure to conduct these hearings today in Brisbane with a particular focus on a health complaint system. Recent developments in this state to create a Health Ombudsman and matters related to the national registration and accreditation scheme for health practitioners. I welcome Dr Michael Cleary, the deputy director general, Health Service and Clinical Innovation, Ms Rachel Welch, director, Regulatory Instruments Unit, and Ms Jan Phillips, the executive director, Health Systems Innovation Branch. Can I thank all three of you for being before us, we do appreciate your time.

All evidence taken at this hearing is protected by parliament privilege as provided by the Victorian Constitution Act 1975 and are further subject to the provisions of the Victorian Parliament Legislative Council Standing Orders, the Parliament of Victoria's Parliamentary Committees Act 2003 and the Defamation Act 2005, and, where applicable, the provisions of reciprocal legislation of Australian states and territories. All evidence is being recorded and you will be provided with a proofed version of the transcript within the next week. Again, I thank you very much for being here and I was just wondering if you had some comments that you would like to make to the committee before I open up to members to ask questions of you.

Dr CLEARY—Well, thank you. Michael Cleary, deputy director general. Could I firstly thank the committee for visiting Queensland and to speaking with us about this piece of legislation, which we think is a cornerstone to the health reform program in Queensland and to have your visit occur, I think, is a reflection of the interest that is in Australia at the moment in relation to complaints management. My colleagues and I have some introductory comments to make but we also have a presentation pack, which we would be pleased to provide.

The CHAIR—That would be very helpful, thank you.

Dr CLEARY—You may wish to flick through as we go forward, but I might indicate when the pages need to turn—

The CHAIR—Yes, synchronised.

Dr CLEARY—So we can synchronise. There is nothing in the pack that I will not be saying, but it is just really, given the volume of information, we thought that these dot points might be of use to you going forward so that you can have a more ready reference to the information rather than having to go back to the transcript.

The CHAIR—Appreciate that, thank you.

Dr CLEARY—Thank you. If you are happy, I might provide a general introduction to the legislation and how we got to the situation that we are in at the moment. The Health Ombudsman Act 2013 was passed by the Queensland Parliament on 20 August this year and centred on 29 August this year. Under this Act, the Queensland Health Ombudsman will have overarching responsibility for health service complaints handling in Queensland. The Health Ombudsman Act was developed to address a series of concerns raised in various reviews and inquiries into complaints handling in Queensland. However, it has been developed particularly to integrate within a comprehensive approach to legislation and the form within Queensland, and this is the second slide.

The framework that I allude to covers both the public and the private sector, and we have drawn on, as I have mentioned to the Chair out of session, some of the experiences in Victoria which were very positive and which we have used in drafting the hospital and health boards legislation. The framework includes the Hospital and Health Boards Act which established 17 hospital and health services to deliver public health services in Queensland, the Private Hospital Facilities Act that provides for the licensing of private hospitals and day clinics to ensure that they provide a high standard of clinical care, the Health Practitioners Regulation National Law that provides for the regulation of individual practitioners, the Mater Public Hospital or Public Health Service Act that recognises the very important the Mater Hospital plays within Queensland as a public hospital, although it is a private facility, the Mental Health Act which establishes a framework for the treatment of involuntary care of mental health patients, and the Queensland Mental Health Commission that sets strategic vision for the delivery of mental health services across government.

On the next slide, the Health Ombudsman will provide for the oversight of the provision of health services within this framework and manage complaints and disciplinary actions within Queensland. Underpinning this framework is the blueprint for better health care in Queensland which provides a focus on the key principles that underpinning health care reform in Queensland, and this was recognised by the Queensland Government as a sentinel document for establishing health or renewable programs in Queensland and, in particular, those related to health.

The key principles are patients and people as the centre of everything we do, ensuring patients have a voice and transparency in public reporting. The overriding goal of the Health Ombudsman will be to protect the health and safety of the public, and to achieve this goal, the Health Ombudsman will seek to embody the blueprint principles and to recognise the major reforms needed to become a contemporary health system. The relevant Health Ombudsman has also been crafted to integrate with the national registration and accreditation scheme for health practitioners and to accommodate nationally agreed principles and initiatives. For example, the Health Ombudsman will include the powers to investigate and take action with respect to unregistered health practitioners, which is a new provision for Queensland.

Moving on to the next slide, the need for the Health Ombudsman Act stems from public concerns that serious allegations against medical practitioners were not being adequately invested in by the appropriate registration bodies. A public interest disclosure was made to the Crime and Misconduct Commission concerning allegations of misconduct by the Medical Board of Queensland. The CMC subsequently appointed Mr Richard Chesterman QC, a former Justice of the Supreme Court to investigate and report back on these concerns.

In his report, the Chesterman report, Mr Chesterman expressed concerns about the way in which serious allegations against medical practitioners were handled by the Medical Board of Queensland and its replacement, the Queensland Board of the Medical Board of Australia, including the time taken to progress and resolve complaints. In his review, Mr Chesterman noted that:

> There are indications that the Queensland Board of the Medical Board of Australia may not have adequately responded to the substance of complaints and may too readily have found complaints to be unsubstantiated.

The Chesterman report also highlighted some confusion in the roles between the national registration boards and the Health Quality Complaints Commission, which is a Queensland entity. The Chesterman report recommended further review to determine whether the Queensland Board made timely and appropriate responses to complaints.

In response to this, the Minister for Health appointed a three person panel led by Dr Kim Forrester, and I should say Dr Forrester is a legal practitioner, and I understand you are meeting with her as well, to review the complaint handling process undertaken by the Queensland Board of the Medical Board of Australia. At the same time, the minister appointed Mr Jeffrey Hunter SC, who is also a legal practitioner, to review the specific cases to determine if it was appropriate for disciplinary action to have been taken, and if referral to the police should have been undertaken in a number of cases.

Moving on to the next slide, Dr Forrester's subsequent report, which is called the Forrester report, concluded that of that 363 of the 596 files considered, that about 60 per cent were not handled in a manner that was timely, appropriate or in compliance with the legislation. In one case, the matter took six and a half years to be finalised.

Moving on to the next slide, specifically the Forrester report concluded with respect to complaint handling under the Health Practitioners Professional Standards Act which predated the National Law, that:

> Outcomes were neither consistent or predictable based on the nature or clinical significance of the complaints and the process of the board failed to protect the public, uphold the standard of practice and maintain public confidence as required under the Health Practitioners Professional Standards Act.

With regard to the matters dealt with by the Queensland Board of the Medical Board of Australia under the Health Practitioners Registration National Law, the report concluded that:

> The process followed by the Queensland Board did not meet the reasonable expectations that notifications are consistently and predictably dealt with in a timely manner.

There were a number of examples were serious notifications indicating that the public was at risk of harm were not handled with the urgency that was required in the particular circumstance and the process followed by the board demonstrated an inability to effectively prioritise and manage the progression of notifications from the time of receipt to the final decision by the board. The review undertaken by Mr Hunter SC resulted in matters relating to six medical practitioners being referred to the Queensland Police Service for investigation into whether or not they had committed a criminal offence.

On the next slide, in addition to these reports, the minister has received a significant volume of correspondence from people who have made complaints about either the Health Quality Complaints Commission or the Australian Health Practitioners Regulation Agency. Medical practitioners who have been subject to investigations that have been inappropriately included, and in one case there was a health practitioner who was investigated and it was only one year later that the case was identified as a one of mistaken identify; that is, that the wrong practitioner had been investigated. The feedback that is been received has been quite substantial and the minister certainly took note of that in considering the way forward in Queensland.

The vast majority of this correspondence raised concerns and made complaints about the way in which the existing organisations had dealt with complaints made by relevant authors. The key themes from the correspondence were a lack of communication from the organisations considering the complaint about the steps being taken to progress the investigation. In many cases, the health practitioners reported they had not been made aware of the complaint. Secondly, that the significant delays in dealing with complaints. Thirdly, a bias or a perceived bias towards medical practitioners. And, fourthly, a perceived lack of disciplinary action against health practitioners in favour of education and training. The correspondence in the three reports clearly demonstrated that reform of the health complaints handling system for health services was urgently needed to restore public confidence.

The minister initiated this reform through the development of the Health Ombudsman Bill. In introducing the bill to parliament, the minister explained that this bill takes on board the findings and recommendations—this is a quote from the minister's introductory speech—this bill takes on board the findings and recommendations made by Mr Chesterman and Dr Forrester in their inquiries that followed the public interest disclosure that the bill seeks to rectify the dysfunctional handling of health complaints in Queensland and establishes the Health Ombudsman as the linchpin of the new accountable health complaints management system.

The minister aimed to ensure that the Health Ombudsman would find an appropriate balance between the rights and needs of patients and the community, and the rights and needs of health service providers. During the second reading of debate, the minister highlighted that:

> The legislation is about ensuring the best possible patient safety. The legislation is also about ensuring clinicians who have a complaint made against them operate within an environment of certainty where the information is disclosed to them, where they have a guarantee that matters of complaints made against them will be resolved in an open and transparent way, and in a fair and consistent way.

On the next slide, the health stakeholders were consulted during the bill's development. The stakeholders included the AMA and other health professional associations, Health Consumers Queensland, the Hospital and Health Services, which are the boards in Queensland, the national boards and the Health Quality and Complaints Commission, as well as our Private Hospitals Association and the government agencies. Some of the stakeholders were also provided with a confidential consultation draft of the bill so that they could provide feedback on the bill.

Over 50 stakeholders were consulted in two phases during the development of the bill. The stakeholders indicated strong support for a number of issues, including the establishment of a single entry point for complaints, investigations being undertaken in a more timely manner, ensuring complaints and health service practitioners are better informed about complaints, giving the Health Ombudsman the power to take

immediate action where the public is at risk, notifying employers of serious matters concerning an employee, addressing standard setting through the national arrangements and strengthening the oversight of the health complaints management system with the minister and the parliamentary committee taking a lead role.

On the next slide, there were also comments from the targeted consultation where stakeholders were provided with the opportunity to better understand the bill. A number of themes of emerged from this, which you could interpret as concerns raised by the constituents: the need for independence, and clearly it is essential that the Health Ombudsman act independently and impartially and in the public interest; clinical input, stakeholders were concerned that the Health Ombudsman or his or her staff were needed to receive appropriate and comprehensive clinical input into both the assessment investigation and disciplinary actions; timeliness, timeliness is consistently raised as a component of a successful health complaints management system and systematic review. Stakeholders were concerned that the Health Ombudsman could lose the capacity to consider systemic issues as provided in the current Health Quality and Complaints Act. These suggestions and views of the stakeholders were considered and incorporated into the bill as appropriate, so we did, in summary, undertake a considerable amount of consultation with the community, both the professional community and the consumers in the state.

On the next slide, just moving on to discuss the Act, the Health Ombudsman Act establishes a comprehensive framework for the management of complaints in Queensland. It repeals the Health Quality and Complaints Commission Act and provides for the appointment of the Queensland Health Ombudsman but the governor and council, and for the establishment of the ombudsman's office. The Act also establishes the position of the director of proceedings who is to be a lawyer and who will be independent, and independently assess the matters to be referred to the Queensland Civil and Administrative Tribunal for disciplinary action.

On the next slide, all complaints, or notifications, as they are referred to under National Law, will be made to the Health Ombudsman. Under the Act, once a complaint has been received by the Health Ombudsman, they will be triaged and the complaint assessed to determine what action is appropriate. Actions may include assessment, local resolution, immediate action, investigation, referral to another entity, referral to the director of proceedings, conciliation or inquiry.

On the next slide, the Act provides for the ombudsman to deal with all complaints but also allows less serious matters to be referred to the national boards. Under the Act, the Health Ombudsman will deal with all serious matters such as professional misconduct or conduct where there may be grounds for suspension of or cancellation of registration. It is anticipated that the ombudsman will refer less serious matters such as health impairment or minor breaches of professional standards to the national boards.

The Health Ombudsman will also be able to refer matters to other agencies, such as the chief health officer, for potential breaches of the private health facilities licensing scheme. The Health Ombudsman will also be able to obtain advice on clinical matters at any time during the assessment and investigation process. For example, by forming panels, committees or accessing other relevant clinical expertise.

Moving to the next slide, the Health Ombudsman may take immediate action against a health practitioner. For example, suspend or place conditions on the registration if there is a credible risk that the practitioner poses a serious risk and the action is necessary to protect the public health or safety, that a practitioner's registration was improperly obtained and the practitioner registration was cancelled or suspended elsewhere. The Act provides for a show cause process but it is not required to be undertaken immediately if it is in the interest of public safety.

On the next slide, the Act enables the Health Ombudsman to notify an employer of a person about whom a complaint has been made if the Health Ombudsman has taken immediate action or is investigating a complaint because a practitioner may have behaved in a way that constitutes professional misconduct or there are potentially grounds for suspension or cancellation of the registration.

On the next slide, the Act extends the current action that the Health Quality and Complaints Commission may take with respect to practitioners who are unregistered health professionals. The Health Ombudsman will be able to take immediate action and/or seek an order from QCAT, which is the Queensland Civil and Administrative Tribunal, to prohibit or place restrictions on the practitioner. Such actions may be taken where

there is a serious risk to the public, unsafe or incompetent practice, financial exploitation, sexual misconduct, discouraging clinically accepted treatment and false or misleading claims.

The New South Wales Health Consumer Complaints Commission has similar powers and it is anticipated that other jurisdictions will introduce similar powers for their health rights bodies in the ensuing years. The Health Ombudsman will also provide for the recognition of orders limiting or prohibiting practice made by other jurisdictions.

On the next slide, the Act sets out clear time frames for managing complaints. These are assessment 30 days plus 30 days if the complaints are complex or if further information is required, local resolution 30 days, plus 30 days if they can be resolved or if further information is required, an investigation generally to be completed within 12 months, but they can be extended on a three monthly basis.

If an investigation goes beyond 12 months, the Health Ombudsman must report publicly on the length of the investigation. If an investigation goes beyond two years, the Health Ombudsman must notify the minister in a Parliamentary Health and Community Services Committee who will have oversight of the Health Ombudsman and will be able to review the performance of the Health Ombudsman if required. The minister will also have the powers to direct an inquiry or investigation by the Health Ombudsman and to require reports from the Health Ombudsman on matters relevant to the Health Ombudsman functions. The minister does not have powers to influence the mechanism by which those inquiries are conducted or the outcome.

Moving on to the next slide and the relationship with AHPRA, with the commencement of the Act next year, Queensland will become a co-regulatory jurisdiction for the purposes of the National Law. The Act establishes the primacy for the Health Ombudsman for all matters related to complaints and notification management. However, it is expected that the ombudsman will build a strong relationship with AHPRA and the national boards.

The Act, on the next slide, the Act provides for a proportion of registration fees for Queensland registrants to be paid from the national scheme to the Health Ombudsman to assist in meeting the costs of complaint management in Queensland. The amount to be paid each year is to be decided by the minister after the consultation with other ministers and the national boards, and AHPRA.

On the next slide, the provisions in the Act provide for the appointment of the Health Ombudsman, the establishment of the Health Ombudsman's office, the negotiation of funding, fund sharing from AHPRA and the disclosure of information. These provisions were commenced on 1 November this year.

On the next slide, it is anticipated that the rest of the Act will commence in mid next year at a date yet to be determined by government. As stressed previously, the independence of the Health Ombudsman is essential for the ombudsman's operation but also to rebuild public trust in the health system. To this end, the Department of Health has engaged KPMG to assist with the implementation of the Act and the recruitment of the Health Ombudsman, as well as the establishment of the office and the policies and procedures that will be needed to operate.

The Health Ombudsman establishment project board has also been convened and comprises senior officers from the Department of Premier and Cabinet, the Department of Health, Queensland Treasury and Trade, the Public Service Commission and, notably, the commission from the New South Wales HCC. It oversees the recruitment process and the establishment of the office.

The recruitment strategy is being managed by KPMG and we hope to have a Health Ombudsman appointed shortly. Negotiations will also commence shortly with AHPRA over the determination of the quantum of funds that will be required to be transferred from AHPRA to the Health Ombudsman. We anticipate that the new Health Ombudsman will have a significant input into the process once appointed and we have been planning for that from the very beginning.

In conclusion, I share the minister's commitment and confidence when he stated in parliament that the bill will 'transform the management of health service complaints in Queensland', and that the bill will create a health complaints management system that is transparent and accountable, and effective, and expeditiously deals

with health services complaints.

I would like to conclude my introductory comments at this time and thank again the committee for taking the opportunity to visit Queensland.

The CHAIR—Well, Dr Cleary, thank you very much for that very comprehensive overview and your presentation that you have provided to us this morning, it has been most helpful. I would like to take you to the point of the stakeholder engagement, and we have just heard from the AMA who have said that they have been working with you, I think, throughout this process, but they have got concerns and they consider significant flaws in this piece of legislation. One of their concerns was that the Health Ombudsman could potentially not have any medical or clinical knowledge, and I think you just said in your presentation that they be a lawyer, or one of the directors was going to be a lawyer. I just would like from you your comments in relation to their concerns about the clinical input into whoever this person may be about making those decisions and how they might perceive and review those complaints. If you could just comment on that in the first instance.

Dr CLEARY—Well, thank you. When we met with the AMA, they did express concerns about a number of provisions in the legislation. When they were provided with the final consultation draft legislation, they raised, I believe, 25 matters with the minister and the department. Of those 25 issues that they raised, 15 of them were resolved in their favour, the department took on board their views and modified the legislation. There were five further matters where the AMA expressed concerns and where the department and the minister of the day made changes to the legislation. There were five areas where the minister and government's view was that the draft legislation should stand.

In relation to the specific issues around the appointment of the Health Ombudsman, there were no restrictions on who can apply for that role, it could be a medical practitioner, it could be a legal practitioner, it could be a nursing practitioner. Whoever is selected, I believe, will have to have high standing within the community. The background will be what they bring to the role but they will certainly require a high standing.

In terms of the legislation and the requirement for clinical consultation, that was outlined by the minister in his second reading speech quite clearly, but the legislation has been drafted, as all current legislation is in Queensland, as facilitatory legislation rather than prescriptive legislation. Although I am a medical practitioner by training, the previous legislation that has been in Queensland is somewhat prescriptive and often requires amendments to be able to comply with contemporary management and so the legislation has been drafted so that it is a facilitatory Act but that anything that is required will be included in the regulations or the subordinate legislation, such as the policies.

We have applied the same principles when we introduce the Hospital and Health Services Act, which is very similar to the provisions that are in Victoria. Again, the legislation there is very high level and facilitatory, and I do not anticipate that will require changes over time. The regulations, though, are where the specifications are included and we would anticipate that those will be changed from time to time, and I believe there was—there recently was a health and other legislation amendment bill that we introduced into parliament to modify some of the legislation that sits within that portfolio, but I think for us it is really the aim of having facilitatory legislation and the more prescriptive elements contained in the regulations.

Mrs PEULICH—Could I just comment on that, please?

The CHAIR—Yes.

Mrs PEULICH—Thank you very much and I might just say thank you for your comprehensive presentation, which I think is illuminating and obviously you guys are doing some very good things, in particular the motion of having a Queensland—I beg your pardon, sort of a separate body formulating strategy for health, I think it is just well done on that initiative. Just to understand the machinery, so the AMA was concerned about the necessity or clinical input being a matter of choice, you mentioned that it would be ensured at both the assessment point as well as the disciplinary action point, could you just tease that out a little bit? What will the regulations stipulate in terms of when clinical input is required?

Dr CLEARY—Thank you. The framework that we are looking at introducing in Queensland, which I would say is still under development in that we are still developing the policies and the procedures that will guide that—

Mrs PEULICH—Absolutely.

Dr CLEARY—But it is been based on the arrangement that they have in New South Wales. In New South Wales, as I understand it from my visit there, which was very informative and from the time that we spent with the commissioner, if a complaint is received, apart from the registration process, and if it—sorry, if a complaint is received and it relates to a medical practitioner, they form a group each week to assess those complaints which includes a representative from the equivalent of the medical board and they determine what immediate action is required as in terms of can this be referred back to a hospital and health service board—

Mrs PEULICH—This is the triaging process.

Dr CLEARY—This is the triaging process. That will include, you know—my belief is that will include not only the clinical input but also the clinical input from the registration board. In addition, in New South Wales, and something that is attractive is that they have a number of medical practitioners employed in the HCCC, and those medical practitioners tend to have specialties in areas such as general practice, emergency medicine and intensive care. But where they require other expertise, before it gets to that assessed level, that triage stage, they will contact specialists in the community who are employed to provide the advice, they are paid a fee for service for those advices, and that information is considered in that initial assessment stage.

In New South Wales where they do not have a medical practitioner as the head of their HCC, that clinical input is gained up front either through staff who are employed practitioners and/or through staff who provide expert advice on a specialty basis in relation to particular matters, and then it is reviewed at the end of each week to determine what the next step should be. I would think the same arrangements apply in Queensland.

Mrs PEULICH—What is the expectation in terms of the finalisation of the readings that would apply, first, and secondly, the concerns expressed were that the Health Ombudsman has, obviously, the power to take immediate action where there are—and you qualify that by saying the public is at serious risk or at risk. Their concern was that the process of appealing that to an administrative tribunal takes time, in Victoria, it is, you know, too extensive, and that in the mean time, a medical practitioner who, perhaps, hypothetically speaking, there could be a different identity, you know, a mix up or whatever, that they may suffer serious consequences whilst that process is in place or perhaps, as my colleague who represents the rural and regional parts of Victoria, that a particular region of Victoria may be denied the services of a valued practitioner. Are you able to comment on that?

Dr CLEARY—Yes, thank you. These types of decisions would be very carefully made. They are not the sorts of decisions that would be made lightly in terms of the impact of decisions that would also need to be taken into account, but there are situations which do arise from time to time which are very clearly are ones where immediate action is required and you would be aware of some circumstances in Queensland where a practitioner was registered who was registered, perhaps, inappropriately. Should that event occur, then this gives the ombudsman the power to determine that either conditions need to be applied, for example, a practitioner who has restrictions in other parts of the world should have the same restrictions applied to their surgical practice in Australia or if someone has become registered but is actually not registered in another country or has been deregistered, then they can take immediate action to resolve that. I think it is a very important step. It is not new to Queensland; the previous legislation that was in place before we moved to the National Law three and a half years ago had that provision in it. In Queensland for quite some years—

Mrs PEULICH—The different options, restrictions, et cetera, were stipulated in the legislation, not in regulation.

Ms WELCH—They are in the previous legislation under our Professional Standards Act, immediate action without show cause notice was a power of the boards at the time. The show cause notice, the show

cause process before taking immediate action is purely—it is a new thing under the National Law and we have heard reports, there has been instances where the show cause action has taken three, four weeks and an action was needed and probably taken, so—

The CHAIR—Can I ask how many instances you have had of unregistered practitioners that you are talking about or inappropriately qualified? Have you got figures on that?

Dr CLEARY—We would not hold those figures; those figures would be held by AHPRA, but there are matters that I am aware of where that has occurred.

The CHAIR—Okay.

Dr CLEARY—The numbers are very small.

The CHAIR—And what is the feedback from AHPRA in relation to this bill?

Dr CLEARY—AHPRA, who I think you are meeting with this afternoon, have been very supportive; although, they do recognise that it is a change to the National Law. I think their concern is really to have national consistency and—

The CHAIR—We do not have that with New South Wales, in any case, do we?

Dr CLEARY—No. We will now have consistency between Queensland and New South Wales, which are principally operating when this Act is fully implemented, will be operating on a similar model. From my time in New South Wales, I think their system seems to be operating very effectively.

There are many challenges with having two complaints entities in the state. We have had an amount of duplication, having the multiple entities has also required us to have memorandums of understanding between each of the entities so that we have a constructive arrangement for information flow, but essentially there is a fair degree of duplication where each of the entities receives a complaint, refers it to the other entity who then make an assessment of the complaint, because one entity is looking at the individual practitioner and the other entity is looking at the complaint on the perspective of the system or the service. There is a degree of duplication that is occurring at the moment and that is what this will hope to reduce.

In terms of the regulations, I do not know whether you wanted to make any comment—Rachel may provide some further advice on the regulations or the development.

MS WELCH—Yes, at this point, the regulation instructions we have had, the regulations are just around the codes and the standards that are to be applied for quality and for decision-making. It does not go into the sort of detail, I think, about clinical expertise. The regulations have been drafted to coincide with the commencement of the Act.

The CHAIR—Okay. Ms Mikakos, do you have a question?

Ms MIKAKOS—Yes. The AMA referred to, as we have explored earlier, their allegation that there is a lack of clinical advice in the processing with the new Health Ombudsman and their assertion was that this was going to make it more difficult to limit a practitioner's area of practice rather than restrict their practice altogether. Now, I understand from your presentation that the Health Ombudsman has the ability to order suspension or cancellation of registration; do they also have the ability to limit a practitioner's area of practice? If you could just clarify that.

Dr CLEARY—Yes, they do have the ability to impose conditions and the conditions would be those that would be consistent with the issue that is been identified. In general terms, you would imagine they would apply with the least restrictive conditions that were required. There are matters that come to me on an almost weekly basis where I am aware that immediate action would be of value. It is not so much around the need to remove practitioner's registration but more around restricting their practice so they can practice in a manner that is safe and protects the community.

Ms MIKAKOS—Okay. If I could ask a further question. Thank you for that clarification. I was so very impressed by the, I guess, the timelines, the greater time limits of investigations in the model that you are proposing, and you referred there also to reporting requirements and the involvement of the minister and the Parliamentary Committee that has oversight. If you could just explain a little bit further the role of the committee and the minister, because I think you have said that the minister could not direct inquiries or the outcome of an investigation. Could you perhaps elaborate a little bit further what the roles of the committee will be and the minister will be, perhaps, if there is an investigation that is gone beyond 12 months?

Dr CLEARY—Thank you. One of the things that the minister addressed in his second reading speech was the differentiation of the role of the Parliamentary Committee versus the Office of the Minister. In that, he identified that the Office of the Minister would be involved in the day to day management of matters that were on foot in terms of anything that the ombudsman required assistance with; whereas, the Parliamentary Committee would be more a second level of oversight and overview the performance of the ombudsman.

In terms of the actions that can be taken once a complaint has exceeded its timeline, that would be up to the committee, but certainly the committee can inquire of the ombudsman the reasons behind the delay and what action is being taken to address that. I think having that two levels of oversight is going to be quite important. Again, neither the minister nor the committee can direct the ombudsman in terms of the way they undertake investigations or the process that they might use. The minister does have the ability to request that the ombudsman undertake an investigation. For example, if there is a serious incident that is occurred, the minister may task the ombudsman with investigating and reporting back to the minister on that particular matter.

The CHAIR—Just to clarify that, so prior to this, could you just clarify for the committee the minister's responsibilities or accountability, or the power that he had or she had, whoever it is, prior to this bill being introduced?

Mrs PEULICH—Sorry, as part of that, could you also just outline how the Parliamentary Committee would acquire knowledge of the functioning of the Health Ombudsman, how is that—is it a public report, is it a report taken in parliament, just as part of that process, so we better understand.

Dr CLEARY—Yes, thank you. To answer the second matter first, the Parliamentary Committee structure in Queensland generally requires an annual—well, there was generally an annual report and those annual reports would be presented to the Parliamentary Committee as well as to parliament. The Parliamentary Committee would then—then may wish to ask for further and better information from the Health Ombudsman and invite them to a hearing. Yes, you are quite right, there would be an annual report and then it would be up to the committee to determine how they would seek to manage the receipt of that report.

The CHAIR—My question?

Dr CLEARY—In terms of the first part of the question, how does it differ from—

The CHAIR—I just wanted clarification about the minister's overarching responsibilities as minister for health services in this state, just a snapshot of, you know, pre and post, really, is what I am trying to glean.

Dr CLEARY—If I could divide my answer up into how does it relate to the Health Quality and Complaints Commission and how does it relate to AHPRA and the national boards, the current legislation, the minister has the ability to request that the Health Quality and Complaints Commission undertake an investigation and provide a report back to the minister. Those provisions are essentially reflected in this new legislation. The powers that the minister had in relation to the Health Quality and Complaints Commission are generally the same, the minister has or the Act does provide for additional powers for the Health Ombudsman to take action if health services are not responding to its recommendations. Whereas, in the current Health Quality and Complaints Commission legislation, they can provide the advice but they do not have an efferent arm to take action.

In relation to the Health Quality and Complaints Commission and provisions, they are very similar in the new legislation with perhaps some strengthening of the arrangements. In relation to complaints that are directed to AHPRA, the minister has—because AHPRA is part of a national system, the minister has very limited ability to make inquiries to determine how well the system is operating. In the arrangement, AHPRA and the ombudsman will be operating in a partnership and the ombudsman will have the ability to identify timelines and performance arrangements for both the ombudsman's office and for AHPRA to ensure that complaints are managed in a timely manner.

The big difference, I believe, will be that the ombudsman will be able to work with AHPRA for those complaints that are being managed by AHPRA and the national boards to determine that they are being managed in a timely and an appropriate manner, and will be able to then report to the minister and to the Parliamentary Committee on both the operation of the Health Ombudsman's Office and the operation of AHPRA as it related to those complaints, that the ombudsman has referred to AHPRA.

The CHAIR—Thank you. Across to you, Mr O'Brien.

Mr O'BRIEN—Thank you, Chair. Thank you. Just following on from that, I would like to just tease out a little bit more what were the problems with the structure of the AHPRA system that were identified in the Forrester, Hunter and Chesterman reviews, and I have got page 7 of the Parliamentary Committee's report. Particularly, how they were said to be better in the past prior to the national scheme, how they were intended to be better into the future, particularly, say, dot point 2, lack of consistency and predictability of outcomes in the board decisions across notifications of a similar nature. In other words, a consistency. That may be related to delay, but can you give us some more details to the precise problems and they were, perhaps, causally related to the national system?

Dr CLEARY—Thank you. My introductory comment, I would have to commend AHPRA for the work that it has done over the last 12 months in terms of the restoration of public confidence in the way the medical registration arrangements are operating in Queensland. Our Queensland Board of the Medical Board of Australia was discontinued some months ago and was replaced by a separate entity, which is a committee established under the National Law. It is made up of four people and those four people include a lawyer, which chairs the committee, and two medical practitioners and a community member. That group have been working through our complaints very actively and have been developing precedence for complaints such that for each complaint that is of a similar nature, a particular precedent is applied to the complaint.

In previous times, and you may wish to ask the AHPRA representatives about this, that precedence system was not in place and so decisions were made on a case by case basis. I think that probably led to some of the comments from Dr Forrester around inconsistent decision-making and not having the precedence. We have been working, we, as in the Department of Health, has been working very closely with AHPRA and the new four person panel to improve their performance around having precedence in place and also for them to have a better oversight of the timeliness of complaints and the complaints management.

The other thing that I have noticed is that the Queensland group has taken on board the minister's policy direction in terms of early and active management is something that is appropriate in certain circumstances and I am aware that they are often making a decision around what the next step is, which they can do under their legislation, which amounts to early and active management rather than what, perhaps, has occurred in the past where when a concern is raised it is investigated and it is only after a time has expired and details have emerged around the complaint that the board would then consider what the next step should be. But in recent times, the expertise of this group is such that they believe they are able to make a determination on some matters where there is clear evidence of unprofessional conduct.

Mr O'BRIEN—I just want to focus back on the differences between the national scheme and the state system, because that is, in essence, the heart of the choices that are being made under the bill, and particularly, I suppose, as I took it from the AMA, the QAMA's similar answers that if it effectively had been a state-administered medical system, that if you are having a complaints process and it is cumbersome, there are losses not only to patients and potential losses to patients, but also doctors in the system, and generally if you are taking doctors out.

Could I just direct you to the third dot point where it talks about considerable delays and inconsistencies in significant number of files due to the cross jurisdictional referral, consultation and information sharing obligations imposed under the current legislation. I am just asking for you to tease out what were the particular problems in that, like why did cases go on for six and a half years or 60 per cent of cases not handled in a timely manner. Were they sending them around all the various different bodies, not knowing how to do it, you know, sitting on someone's desk? Just in comparison to what you hope and perhaps what occurred beforehand.

Dr CLEARY—Could I take that question on notice because I do not have a response that I could provide which would be fulsome. I would believe that Dr Forrester would be able to provide a much more detailed—

The CHAIR—Yes.

Mr O'BRIEN—I will certainly be taking it up with the Parliamentary Committee and to Dr Forrester, but to me it is the heart of the matter if you look at it from a systemic point of view.

Dr CLEARY—There is no suggestion that Dr Forrester, in terms of the review that she undertook, that it was undertaken in a manner that was confidential, so we as the Department of Health were not aware of the detail. We did have a role in setting the terms of reference, the minister set the terms of reference for the reviews, but in terms of the specifications and the detail, because the practitioner's records are confidential in a very—are confidential, we were not aware of the level of detail that you are probably seeking, so I would think the best person to provide that—

The CHAIR—Perhaps it is more appropriate if we do ask Dr Forrester.

Mr O'BRIEN—We will fill it up on notice. If I could just then ask you, then, perhaps move forward to the new bill, could you enlighten us as to specifically what is sought to be achieved by a move back to a state basis in terms of more nimble response? I know there are specific timelines, but that more fundamental decision, is the department able to make a comment on where it sees that will have advantages or disadvantages?

Dr CLEARY—The big advantages, I think, will be having the single point of entry for all of the complaints that are received, the complaints and the notifications, and for them to be dealt with expeditiously. In terms of New South Wales, my understanding is that 25 per cent of the complaints that they receive are resolved in a very short period of time either because they are referred to another agency for management to a hospital and health service at the board or to the private hospital's regulatory agency or other equivalent entity. Then within three months, another 25 per cent of those matters are resolved.

Personally, I think one of the reasons for that is the early active management of matters rather than having an investigation or a detailed assessment of a matter. Where there is a clear complaint that can be resolved, then it is put into the resolution pathway. If there is a matter that is serious and needs further consideration, then obviously that is referred to the appropriate agency, but I think it is very important to have that triage function at the beginning of a complaint and set the pathway for resolution. Whereas, the current arrangement has been difficult, firstly, because there is often an assessment pathway before a decision is made and, secondly, because there is cross-referral, across numbers of departments to determine if they have a complaint, if the complaint is relevant to their particular area. Because of that multiple entry points, there are safeguards in place to make sure that there is no duplication, but it does add to the time taken to review a matter and the time to be able to set a specific direction on how a matter should be managed.

The CHAIR—Thank you for that answer. Ms Millar.

Ms MILLAR—Yes, in terms of the central aim being to protect the public, I am interested in the employer's notification, and you have listed the grounds under which employers are required to be notified. Are there any timelines for that notification to occur once a decision—you have talked about the assessment pathway, once you have determined that it is either serious or there is immediate action, is there any timeline under which you must then notify employers?

Ms WELCH—Firstly, it is not a must, there is no requirement to. It is an assessment case by case and, no, there are no time frames specified. It also could be at any point along the management line, so it might be very serious as soon as the Health Ombudsman becomes aware of it, it might be a few months later after a significant investigation has been undertaken, but it isn't a must, either, that should be made clear. There are going to be instances where it is not appropriate for the employer to be notified and then there will be others where the employer needs to be told straight away. I should also just state that other laws will still apply, so industrial laws and anti-discrimination laws will still apply to that employer in their dealings with the employee.

The CHAIR—If it was triaged and it was a serious matter, then you would obviously notify the employer if it was deemed that the public were at risk, but if it was just some minor matter that needed to be addressed by another entity, you would not necessarily notify the employer. Is that correct?

Ms WELCH—That is right.

Ms MILLAR—That is, I guess, one of the key challenges in terms of the protection of the public as in terms of the timeline under which the employer is then notified, that there is a potential problem, so thank you for that. The other question I had was in relation to the less serious matters that would then potentially be referred to AHPRA to investigate. What sort of guarantees do you have about, then, the timeliness with which they are going to review those matters that have been referred by the Health Ombudsman so you ensure that there is no six and a half years for those types of matters?

Ms WELCH—I do not know that I can give a definitive answer on that. The Health Ombudsman Act applies to AHPRA, we have not excluded it, so in our front end of our National Law Act where we exclude what Acts do not apply to the national scheme, we have not included the Health Ombudsman. Technically, AHPRA still has to abide by what we have got in the Health Ombudsman Act. I do not think we have got specific targeted time frames for AHPRA, but they are answerable to the Health Ombudsman and the Health Ombudsman will be able to take back any matter that they have referred to AHPRA at any time. If they think that there is delay or there are problems with it, they can take that back and take over the management.

The CHAIR—Would that be reported to the minister as well if there was, as you just describe, an instance?

Ms WELCH—There is not a specific requirement to report to the minister but it is certainly something the minister could be asked to be informed of. Given that the matters that will be referred to the national boards will be of a less significant nature, it probably will come down to an operational arrangement between AHPRA and the Health Ombudsman rather than something of significance that needs to be reported.

The CHAIR—But just on that issue, a lot of the evidence that we are hearing is that the issue is the time frames and AHPRA has been under considerable criticism because of their extended time frame, so whether it is an individual waiting for the outcome of a relatively minor investigation that AHPRA is conducting, it would seem that they, too, should have a fair hearing and have their case dealt with, and that is what we are concerned about, is the time frames that AHPRA is taking to undertake the—

Mr O'BRIEN—It is a known resolution of a minor matter might turn it into a serious matter.

Ms WELCH—Well, the responsibility under the Act still lies with the Health Ombudsman even when they refer it to AHPRA. If there is a delay, the Health Ombudsman is still responsible and will be responsible to the minister and the Parliamentary Committee over their processes and what they are referring to AHPRA. Also, the Parliamentary Committee's role is quite expanded now and they can actually monitor and review AHPRA, and—

The CHAIR—I thought we might ask the committee themselves about their input—

Ms WELCH—Yes, specifically in the Act they can require information about performance of AHPRA, so they have oversight of AHPRA.

Dr CLEARY—One other comment was that AHPRA can—sorry, the ombudsman can seek information from AHPRA to allow the ombudsman to consolidate reports and so the ombudsman will be able to monitor the performance of AHPRA throughout that process.

The types of things that I would have envisaged would be referred to the boards would be health practitioners with health problems, be it mental health illness or dependency, and they would be matters that would be monitored through one of the existing subcommittees of the board and would tend to be a long-term management of the practitioner rather than dealing with a complaint. The other issues that the boards would deal with would be registration and then the third arm would be a professional practice where the professional practice is substandard. I think one of the things that we possibly have not articulated as well in the explanation of the legislation to board of groups is, there is a move from complaints resolution to competency management, so it is in the—

Mrs PEULICH—It is really strengthening the governance measures.

Dr CLEARY—Yes.

Mrs PEULICH—I think it makes a lot of sense to split consumer complaints from governance of accreditation registration of medicos and so forth. I am glad you have actually ended on that because are you able to actually articulate—and I think it is sensible, it makes great sense. Are you able to articulate the rationale underpinning that improvement or the adoption of the reform in the context of a governance practice?

Dr CLEARY—Certainly drawing on the experience of the United Kingdom which has had a number of matters that have triggered reviews there, but they have moved from complaints resolution to the competency of a practitioner because resolving a complaint is slightly different to ensuring that a practitioner has appropriate knowledge, skills and abilities to treat and manage patients, so a minor complaint may be associated with the competency issue of some substance and a more serious complaint may not be associated with the capability and capacity issues. One of the important things is to be able to determine whether underpinning the complaint there is an issue or capacity, or competence, and that is something that the boards will need to look at.

Mrs PEULICH—I understand and accept that, but do not you also, or do you have a view that there is actually a conflict of interest that is inherent in the same body undertaking complaints investigations and being responsible for determinations about accreditation and registration? If you make a decision—if it is all undertaken by the same body—how likely are you—and if you can make a wrong decision for the same body to actually fix that up, does it make good sense in terms of governance to actually split those functions?

Dr CLEARY—Thank you. In terms of the governance structure, and I apologise, I might have misunderstood the question, the director of proceedings is the arm of the Office of the Health Ombudsman that takes—the action takes proceedings to the court system in Queensland to seek to have registration arrangements modified. That person is completely independent of the ombudsman. They may sit within the ombudsman's office but they are in no way influenced by, directed by or guided by the ombudsman. The ombudsman has a role in taking the complaints, triaging the complaints, managing the mediation, managing the timelines, assisting with the investigations, but once a matter is referred to the director of proceedings, the director of proceedings is totally independent of the ombudsman who may have referred the matter, but the director of proceedings is then totally independent and takes decisions as an independent entity.

A director of proceedings can then progress a matter through to QCAT or take other actions or refer a matter back to the ombudsman, so although they are within the office, they are, as a statutory position, are independent of the ombudsman and, again, independent, therefore, of the minister and the committee, so they form that independent function.

Ms WELCH—Sorry, could I make a correction?

The CHAIR—Yes.

Ms WELCH—I am very sorry, in your question around employers being notified, the ombudsman must notify the employer, it isn't discretionary, I was wrong there. I had a little doubt so I went and had a look. The employer must be notified or any person that the Health Ombudsman thinks is an employer must be notified. There is no time frame around when they must be notified and there are some exceptions to that must, so if the Health Ombudsman believes it will prejudice an investigation or there are other concerns, he does not have to or she does not have to, but I do apologise for that.

The CHAIR—No, thank you for that correction, that is most helpful. I do not believe there are any further questions, so can I, on behalf of the committee, thank all of you very much for being before us this morning. The evidence that you have provided to us has been most helpful, so, again, thank you very much.

Dr CLEARY—Thank you for the time.

Witnesses withdrew.

Hearing suspended.

PROOF VERSION ONLY

LEGAL AND SOCIAL ISSUES LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Brisbane—22 November 2013

Members

Ms G. Crozier
Mrs I. Peulich
Mr D. O'Brien
Ms A. Millar
Ms J. Mikakos

Chair: Ms G. Crozier

Staff

Senior Secretary: Richard Willis

Witnesses

Health and Community Services Committee:

Mr T. Ruthenberg, Chair, Member for Kallangur;

Mr D. Shuttleworth, Member for Ferny Grove;

Mr J. Hathaway, Member for Townsville; and

Dr A. Douglas, Member for Gaven.

NECESSARY CORRECTIONS TO BE NOTIFIED TO SECRETARY OF COMMITTEE

The CHAIR—Thank you very much to all of you for being before us this morning and having us to your parliament. It is a great pleasure to be here and to conduct these hearings with a particular focus on the health complaints system. Recent developments in this state are to create a health ombudsman and matters related to the national registration and accreditation scheme for health practitioners. I welcome Mr Trevor Ruthenberg, the chair and member for Kallangur, Mr Dale Shuttleworth, member for Ferny Grove., Dr Alex Douglas, member for Gaven, and Mr John Hathaway, member for Townsville. Thank you very much.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Victorian Constitution Act 1975 and further subject to the provisions of the Victorian Parliament Legislative Council Standing Orders, the Parliament of Victoria's Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation of Australian states and territories. All evidence is being recorded and you will be provided with a transcript within the next week of today's proceedings.

I am not sure if you would like to make an opening statement in relation to the work that you have been conducting. If you are prepared to do so, we would be very keen to hear that. I would like to open to our members to ask questions in relation to your process and what you have been—

Mr RUTHENBERG—Sure, thank you, Madam Chair, I appreciate that. For whatever we can offer you, hopefully it is helpful. Firstly, can I please offer the apologies of the deputy chair, Ms Jo-Ann Miller, she is unfortunately unable to be here today. And also of Mr Jon Krause, member for Beaudesert, who is also unable to be here. He and his wife had another baby last night.

The CHAIR—Very nice.

Mr RUTHENBERG—We excused him.

The CHAIR—Indeed.

Mr RUTHENBERG—Can I also state that I stand by the report that we produced but I would like you to understand very clearly that the committee system here in the Queensland Parliament is that we have five government members, two non-government members and Dr Douglas is one of the non-government members and both non-government members submitted a statement of reservation to the report. During the process, it may be worth just making sure that Dr Douglas has an opportunity to also express his thoughts.

The CHAIR—We would be very keen to hear from Dr Douglas.

Mr RUTHENBERG—Yes. And I think, substantially, if you read that, Dr Douglas's reservation as well as the opposition's reservation were extensively the same. I do stand by the report and we are doing our best to remember what we wrote in the report. Unfortunately, as you would well understand, you do something and you move on, so we have come back to it, somewhat, and it will be important for us anyway because the committee will have substantial oversight capability of the new ombudsman, certainly much more than what we had over the Quality Health Complaints—or we have over the Quality Health Complains Commission. The ombudsman legislation came about and was driven by the outcome of three inquiries, and I believe that you have got the author of the Forrester report coming in shortly.

The CHAIR—That is correct.

Mr RUTHENBERG—I will leave that where it is, but basically the outcomes of those three inquiries ended up or reports ended up with what we have. I think the legislation substantially addresses the majority of the concerns raised in those reports.

One of the things I want to point out, as you were well clear, typically when you are examining legislation as a committee, you usually find something that you think needs to be reviewed or should be tweaked or should be—in fact, the committee, on a piece of legislation—our recommendations were not based on the substance of the legislation being proposed. I think that reflects well on those who are drafting it and the amount of consultation that was carried out, and it was fairly extensive. We did a lot of work on this, we held fairly

substantial hearings and I always try and ensure that we have a very balanced, irrespective of our political bias, we have a very balanced group of people coming in, that we can hear them. I think you are silly if you try and maintain just a bias. The whole point of a committee system is to ensure is that we have an as wholesome legislation as we can provide. I think that simply emphasises the amount of work that was done on this particular bill and, consequently, legislation.

I just want to touch on two areas of concern. The report, as I understand it, we covered off and addressed as many of the substantial concerns as we could, as we understood, and so we tried to address all of those concerns based on our inquiries and submissions, but I want to address two things. One is there is a very strong governance oversight in the bill, and coming out of large, not-for-profit organisation prior to coming to politics and prior to them doing a very large multinational business organisation, one of my emphasis always is, and the committee will hear me talk about this, is that our role is a governance focus, and so I have always tried to concentrate on that governance level because I think if you get the governance level right, that is the foundation on which everything else emanates from.

The oversight of the ombudsman in Queensland has a very strong governance layer, not only from the minister but also from the committee. The committee has substantial powers. Not as powerful as the PCMC in Queensland but certainly has substantial power. We can call on reports, it is not just a report coming to us inquiring into that report, we can actually call on reports if we need to call on the ombudsman and/or AHPRA to give us information, which is a fairly far step into an area we have never had before. There is substantial oversight placed on that.

If the committee feels that something is not quite right, from a systemic perspective, we have the authority to request information there and not just wait for an annual report to turn up, we can actually be proactive in our operation. I think that is important to understand that. We actually asked for a little bit of clarifications. One of our recommendations was the minister give us clarification on the two roles. In his second reading speech, the minister clarified that to a degree where he talked about his role being the minister having ministerial oversight and our role looking at it from a systemic perspective, but the capacity of the committee to do that is substantial. We have yet to properly clarify that and we will be trying to work with the minister to come up with a common set of reporting principles and requirements so that we are not at cross swords here, we do not play onerous reporting requirements on the organisation, but that we can get meaningful reports and understanding of the current operations of the ombudsman.

The ombudsman has yet to be selected; that process is under way. The committee has some responsibilities in that process. In fact, the minister wrote to us and asked us how we wanted to conduct that and our response to him was: we would like to see the finalists and their resumes, and then have an opportunity to comment on that back to the minister. I also want to talk about the independence of the ombudsman because I think that is important. We can deal with all the other issues during your questioning, but it is important to understand that the ombudsman is, in my opinion, and substantially in our opinion, is significantly independent from the minister. The minister cannot instruct the ombudsman except to request information, so it can request a report. The minister cannot ask the ombudsman, for example, or direct or instruct the ombudsman to carry out or conduct an investigation in a particular manner, so the ombudsman is substantially independent from the minister.

Further than that, though, about 18 months ago, we implemented, as did most states across Australia, HHS, Health and Hospital Services. We have 17 of those boards. We have 17 independent health providers in Queensland now that have their own boards, and that is right across, so those boards have constituted requirements and then they have their own operating capacity. Queensland Health two years ago, three years ago were the health provider across the state. Queensland Health now are substantially the regulator and the health hospital boards are now the providers and so that actually gives a layer of independence also for the ombudsman to work with. If the ombudsman is working with a provider, they are with the HHS, they are not working with the minister. I think that in itself is also—that is the other point I want to make here, is that the legislation for the ombudsman does not stand on its own; there is other legislation that runs around it that gives it its robust nature.

Another area, for example, just to explain that point, is that in the area of privacy, for example, what a minister and his staff can and cannot divulge has its own legislation, and so when we talk about the minister

being able to request information, that information can be protected because there is other legislation that protects what the minister and their staff can and cannot divulge publicly. I guess I will leave it at that. I think that I have publicly stated this before, I think that the drafters did an excellent job in substantially addressing the issues that we were seeing here in Queensland.

The CHAIR—Okay. Thank you very much for that overview, Mr Ruthenberg. Before we do go on to questions, could I ask Dr Douglas if he does have any comments that he would like to make at this point in time to the committee.

Dr DOUGLAS—Yes. I mean, I did have a sitting report and, you know, it is fairly detailed, it is worth a read. It is based on research. I mean, I have been involved in this for a long time, I formed PCMC chair, and ethics committee chairman. I see that there's a set of top-tier problems and a second-tier set of problems with the legislation and I detailed that in my response. Now, the critical problem with the system is one which has sort of been said to have been addressed by the chair which was the critical problem of the minister addressing the Ombudsman directly. I am not convinced that that is not anything other than really a one-way model. I think it's a one-way model rather than a two-way model and I'm concerned that there would be – I accept that the minister can't direct specific investigations but I think that there's a difficult problem with regards to how that is being addressed without really a fixed independence of the Ombudsman themselves.

The second problem in the top tier is that they are endorsing what is a legalistic approach to it. In other words, the idea that it will be going back into an adversarial model, more likely a lawyer-driven model. Under the current interim medical board the head of the board is a lawyer. Remember medical systems inherently are non-adversarial. We actually have an inquisitorial system in medicine where guilty until proven innocent. So it's a sort or reverse to the standard of things. So that inherently leads to problems. There's lots of literature on that.

There's no set clinical reference committee which is dictated under the regulation. They can actually form the committees. The best system that exists in Australia is the one in New South Wales currently, and I would encourage you to go and look at that, where the set reference committee – the Ombudsman has a direct inter-relationship. I think that rather that using the idea that you can empanel those people, I think that if they're actually set under the regulation you'll find that that's far more successful. They've got a 10-year history of it.

The other problem is the issue of the lowest common denominator. It's a big issue in medicine, particularly with regards to investigating things. The lowest common denominator thing is actually you have a base result which satisfies a group of people but may not satisfy things like clinical excellence, on one hand, so medical-type result, nursing-type result as opposed to – and also possibly specific judicial – addressing the fairness to the individuals involved. So if you have a lowest common denominator thing you actually are trying to appease most people to some degree. Now, in medicine that's not a good result. Particularly if you've got a problem and particularly in systemic issues, you may well then allow a systemic issue to roll on for a much longer period of time. It's actually dangerous.

Now, I say so with regards to some specific examples which I mentioned in prosecuting on behalf of some of your colleagues in Victoria currently with chiropractors. You may or may not be aware of what that is.

The CHAIR—Well aware of that case.

Dr DOUGLAS—Okay, right. You know your health minister is a chiropractor which is a problem. It is not necessarily a problem but it may be a problem and it os a system problem, possibly. Now, I say this—

The CHAIR—Just on that point, you are referring from AHPRA a chiropractor looking into the—

Dr DOUGLAS—I do not want to get too involved in it. I will talk about it—but I am just saying that when you have lowest common denominator results you don't get excellence in clinical practice. In any investigative process you actually want to use the process to improve the system as you are going along. So every part is a component because medicine is a collaborative model that actually cares. So you are actually trying to build better answers through the existing things that you do. So the investigation is conducted from a

body like AHRPA or in this process, have an ombudsman—you want to actually get something that you can build on that will add to your system and make it better that you may not be aware of and you can only establish it through another method.

Now, when you use lowest common denominator model—politicians like them because you can actually get more measurable results and you get them in a more timely process but they may not necessarily be in the interests of individuals from both a medical excellence type process and also to address judicial fairness for those individuals.

Mrs PEULICH —Dr Douglas, just on the idea of the collaborative model, even in a hospital facility or a medical facility, ultimately someone has to make the call.

Dr DOUGLAS—That is right.

Mrs PEULICH —So a collaborative model only takes us so far.

Dr DOUGLAS—That is right. In a medical model it is ultimately the doctor that must carry the responsibility. That is why they have to carry medical defence and all decisions – whilst you do not want people to be practising in a risk-averse way, you want them to make decisions and the more decisions they make that are correct, the better they get at it. Patterns of behaviour tend to develop where you get people making repetitive errors, in some cases in systemic issues. Sometimes they do not know and sometimes the group who is the participant, they do not know either, and they do not know until you do an investigation.

But you do not want the lowest common denominator – lowest common denominators end up when you change systems regularly and there is not sort of like a corporate knowledge in the transition of ownership. I am concerned about that enterprise bargaining currently we have just started getting the HQCC working and there does not seem to be enough of a belief that maybe they need to incorporate the HQCC enough into – that is the Health Quality and Complaints Commission. I have actually put that as a second-tier issue.

I also think the issue of the legal-type approach is a very, very concerning one in that I am not saying that you have to have a medical person – but inherently if the person does not have those dual qualifications, I see it as a bit problem. Even if they were – you know, nursing training, even psychology, but to have purely as a legal thing, if the framework is a completely different framework, it's adversarial thinking and it's negotiating a result, a mitigating process. Medicine is not inherently – most medical things are not necessarily mitigating. They are actually addressing – you know, there is an answer. It is a bit like engineering. You build a bridge so that it actually holds up and it does not fall over.

The other problem is I felt there is a top-tier problem. I thought it was too critical on one person. Inherently, if you are ultimately dependent just on one person, particularly when you are trying to address some of those things, you do not realise that those people become exhausted by the process and there is a fatigue associated with it. That happens to all of them and, in the transition process particularly when you are actually carrying from one system over a new system, they are sort overwhelmed by a variety of different things and then you sort of tend to get prioritisation of things and there are no clear definition of how those priorities should really be allocated. If they have not got an empanel committee which is set by regulation to refer to, it may be that the priorities become sort of a little disturbed.

Now, we would say, well, you are relying on the professionalism of the individual, but it is a bit of guesswork and you are taking a bit of a punt and I do not know whether – in medicine you just cannot take punts. In a modern world you have got to reduce your capacity to make mistakes and you build in systems where you do not actually inherently start off with the potential to actually make an error. I think that was a problem in the second tier and—sorry, I will be brief. I know I have said a lot here.

In the second tier I think that multiple changes to the models over many years need to be considered. You need to really say at what speed are you going to introduce it so that you really transition at a rate where you do not lose all the good things that you have already got and you actually build in the good things and probably discard the bad one. When you chop and change and say, 'Gee, this looks like a really good idea,' just be inherently thinking, 'What's so bad about what I've already got,' and maybe look towards addressing

that problem.

Look, I also thought in our case we do not actually have an upper house reference committee, which I think is—it is difficult. We're a unicameral parliament and so, necessarily, if you have complaints it becomes then difficult for people to prosecute arguments that they actually have not got someone that they can – I actually think the upper house is quite good. They can get people to come along. I think that currently if you look at what is going on here, there's certainly significant challenges to the committee system which then limits the problem. You do not inherently have that but ultimately you could have variations of it and you should be cautious and plan for it.

The CHAIR—Thank you for those comments. Can I just ask if any other member—

Mr RUTHENBERG—Madam Chair, can I just make sure there is a clarification in one of the statements I made?

The CHAIR—Yes.

Mr RUTHENBERG—This is to do with the independence of the Ombudsman. Clause 27 of the bill provides that the Health Ombudsman can act independently, impartially and in the public interest. Clause 28 clarifies that a minister may direct the Health Ombudsman to undertake an investigation (clause 81) or conduct an inquiry (clause 152). However, the Health Ombudsman is subject to direction by anyone else. I just want to make sure that that is clearly understood.

The CHAIR—Thank you for that clarification.

Mrs PEULICH —I think that point was made earlier.

The CHAIR—Yes, I think—

Mr RUTHENBERG—I think he said it would be not a direction as to how to conduct the inquiry but—

The CHAIR—Yes, the operation—

Mr RUTHENBERG—The inquiry of the investigation.

The CHAIR—Mr Shuttleworth or Mr Hathaway, would you like to make any further comment?

Mr SHUTTLEWORTH—No, not at this stage.

Mr HATHAWAY—No, thank you.

The CHAIR—Do you want to seek further clarification?

Mrs PEULICH —Just in relation to Dr Douglas. How many years have you served here?

Dr DOUGLAS—Eight years or something.

Mrs PEULICH —So you have obviously got quite a bit of experience. So you are the appropriate person that I can pitch this to. You made the comment about this being a unicameral parliament, obviously quite different to Victoria where we have a fairly robust upper house. Are you able to just explain in brief the functions of the Health and Community Service Committee of the Queensland Parliament in terms of its powers?

The CHAIR—Well, that might be for the chair to—

Dr DOUGLAS—It's a portfolio committee but I think Trevor could probably—I mean, if there is

anything else I will fill in the gaps. Do you want to answer that, Trevor?

Mr RUTHENBERG—Is that in relation to the ombudsman?

The CHAIR—No. Generally, I think.

Mrs PEULICH —Generally.

The CHAIR—How it operates.

Mrs PEULICH —I think you were basically inferring—and I am not quite sure whether this is what you meant – that the ombudsman ought to be an officer of the parliament. Is that what you were basically referring to as one of their—

Mr RUTHENBERG—Well, no, it's a standard sort of ombudsman. Yes, so he is appointed by the parliament.

Mrs PEULICH —By the parliament.

Mr RUTHENBERG—Yes. So he is responsible back to the parliament.

Mrs PEULICH —Back to parliament.

Mr RUTHENBERG—Yes. The committee thing should be a link that—

Mrs PEULICH —Sorry, I am just trying to understand—

The CHAIR—I think it was the process—

Mrs PEULICH —Whether your committee work has greater powers than perhaps some of our committees do.

Mr RUTHENBERG—It may be that we just talk about the committee system in Queensland generally first.

Mrs PEULICH —Yes.

Mr RUTHENBERG—This is a fairly new system for Queensland. It has been in probably, what, three years now, Alex, somewhere around there?

Dr DOUGLAS—2011 or late 2011.

Mr RUTHENBERG—There was a lot of work done to determine how the parliament can include the public more in law-making. So this particular committee, our committee for example, oversees four different ministers. A bill will come to parliament and typically the bill then will be referred immediately to the relevant committee.

Mrs PEULICH —So it is a New Zealand model.

Mr RUTHENBERG—Similar.

Dr DOUGLAS—New Zealand model with some modifications, yes.

Mr RUTHENBERG—Our responsibility then is to take that bill to seek submissions from the public hold inquiries and determine and make recommendations consequential to that information. Secondarily, we can be referred an inquiry which is not subject to a bill but simply an inquiry. Earlier, for example, this year we presented our inquiry on palliative care and disability services, which just by the way I think is probably

the most substantial review ever done by any parliamentary precinct anywhere in the world. So that was an inquiry with no particular expectation on the outcome but we looked at that issue substantially and made our recommendations. Thirdly, as a committee we can instigate our own inquiries substantially around public works and public accounts, so within the portfolio areas that we look at. For example, we are talking about health now. One of the things we looked at was we have been following up on the Auditor-General's focus on some of the IT systems within health and we have held several inquiries—not inquiries; several public inquiries, I guess.

The CHAIR—Hearings?

Mr RUTHENBERG—Hearings where we bring people in and have a talk to them, relevant department members, et cetera, to follow that up and we have been chasing that now for some months, just looking at that. The function of the committee is an important function. Our committee we look at health, communities, disabilities, national parks, sports and racing and Aboriginal and Torres Strait Islander and multicultural affairs plus we have three commissions that we look at: Family Responsibilities Commission, which is a joint federal-state commission, we have Quality Health Complaints Commission and Child Commission. We have the three of those as well. Whenever a bill comes to parliament related to any of that, it comes to the committee, which is consequently where this comes from.

The CHAIR—With your role with this committee in relation to this bill, you have an ongoing responsibility.

Mr RUTHENBERG—Oversight.

The CHAIR—Oversight. How much do you anticipate or how much involvement do you anticipate the committee to have with that particular oversight?

Mr RUTHENBERG—Look, right now we are establishing that. Our former experience is with the Quality Health Complaints Commission which will be going away and the ombudsman will be picking it up. Our role there really was very much an oversight. So we would, in effect, wait for a report to come, examine the report and then we could hold hearings or request further information based on that report coming to us. So it is a very reactive role. The role, however, with the ombudsman will give us far more proactive capability, far more so than other places. If you look at Part 14, 179 of the bill – and I will just summarise that here. The functions that the new legislation give us in regard to the ombudsman is to monitor and view the operation of the health complaints system.

Mr O'BRIEN—Sorry, not our report. It is the actual bill.

The CHAIR—The bill.

Mr RUTHENBERG—The bill, sorry.

Mr O'BRIEN—Part 14, yes, parliamentary committee's role.

Mr RUTHENBERG—Identify and report on ways the health complaints system might be improved, monitor and view the Health Ombudsman's performance, monitor and review AHPRA and the 14 national boards performance and their functions as it relates to health, conduct and performance of health practitioners in Queensland, but not the registration of practitioners. This really is system focused. Examine reports of the Health Ombudsman, AHRPA and national boards, advise the minister on appointments of the Health Ombudsman and report to parliament on matters referred to the committee or other matters identified by the committee.

The oversight powers of the board, our committee will aim to ensure that the new health complaints system is accountable and transparent and effectively performs its role of protecting the Queensland public. If you look at the primary principle of the bill, being the safety of the public—I mean, that's the fundamental existence of the bill. We have yet to establish the parameters that we'll operate around that. It's very, very new, but our expectation is that we will work with the minister, as I said before. We will work with the minister so that we

end up with a consistent report function that will allow us to look at and dive down into different areas. Coming out of the corporate setting, I am hoping that that will help us to establish that reporting hierarchy.

The CHAIR—We heard from the AMA this morning and they, as you are well aware, have got—they believe there are significant flaws in this bill, which I think goes to partly what Dr Douglas is referring to.

Dr DOUGLAS—I could go much further if you wanted to. I could really tell you what I really think.

Mrs PEULICH —I think we get the gist.

The CHAIR—We get the gist. I would just like some comments from the committee in relation to their concerns and how you have come collectively together to address those concerns, or have you not? You have your report, which I have not read, I might add.

Dr DOUGLAS—If I could just add to what Trevor said. What they have decided to do is in some ways there is a model where the thing is called the Parliamentary Crime and Misconduct Committee which is a very powerful committee here. There is a lot of trouble going on at the moment.

The CHAIR—So we believe.

Dr DOUGLAS—Right, okay. The idea was within the legislation to sort of have this oversight committee having a role not dissimilar to the PCMCs over the health model. Now, that is not a bad idea in some ways but it has to come with generally a lot of rules that really will apply to it on both sides. An element of reaching agreement – inherently in medicine a lot of things are confidential. All of a sudden this committee would have to start embracing a lot more confidentiality of matters, otherwise the Ombudsman and the people would not be able to communicate, even in general terms. Confidentiality means it is not even like whispering and stuff. Then the members of the committee would then have to understand they are bound by very strict rules forever, not just for 10 years, 13 years.

The CHAIR—We have a very strict privacy law in Victoria in relation to that. I am a former nurse and former midwife and worked in the public system, so I know exactly what you are talking about.

Dr DOUGLAS—There you go. Yes, that is right.

The CHAIR—But in relation to those concerns and specifically the issues surrounding, as you said, the adversarial approach from the Health Ombudsman having that legal person if that was to be appointed or whoever, but their concern is the lack of clinical expertise making these decisions. Can you comment on that?

Mr HATHAWAY—Look, can I comment? Whilst I was not here for the testimony for Dr Rowan this morning, he expressed all those similar views during our public hearings. I think you heard Dr Cleary say today that there was about 25 major points of contention, et cetera. The department met about 15 of those.

The CHAIR—We did not get to the five, actually.

Mr HATHAWAY—Or five. I've forgotten what the numbers were. The thing I can tell you, from the AMA's point of view, would be the lack of clinical representation on the Ombudsman, ie, potentially a lawyer could be the ombudsman.

The minister covered that off in his second reading quite clearly and said, 'It's not prescriptive. It doesn't preclude that clinical representation as the ombudsman,' and as Dr Douglas has indicated, he could be a clinician and a legal eagle as well. So rather than be prescriptive, I took comfort from the fact that sometimes you get group think or professional think, et cetera, which will lead you down a particular pathway. I am not saying that the ombudsman does not need reference to clinical experience; I accept that. But the ability for him to be appointed if he is a lawyer, a banker, or whatever—it is just the ability to be objective; to weigh up the risk clearly if he needs to take speedy immediate actions, which is key.

In fact on cross-examination of Dr Rowan I specifically asked questions about that and I understand where the AMA is coming from about protection of the practitioner. I do understand that. But in one of his responses to my questions, Dr Rowan said, 'What is in the best interests of doctors is in the best interests of patients.' He does flow on to say further that, 'It's also what is in the best interests of patients is in the best interests of doctors.' He was trying to demonstrate that nexus. I said, 'Ultimately the primary reason for this bill is for the safety of the Queensland public and patients.' So that is the overarching principle. Everything is secondary to that.

The CHAIR—Thank you.

Mr RUTHENBERG—Sorry, can I add to that?

The CHAIR—Yes.

Mr RUTHENBERG—Just to clarify, our committee can actually request information also from the boards and from the ombudsman. So we can be very, very proactive. Just on the employment of—

Mrs PEULICH—But are there limitations on what you can receive or what may be exempt?

Mr RUTHENBERG—I do not think so. I think we are pretty open in what we can request for. We will clarify that for you shortly. One of the reasons why I was fairly comfortable with the way the legislation is about appointing an ombudsman is written, in New South Wales I believe the ombudsman there has been in place for over a decade and he is not a doctor. In fact when we talk to him as a hearing, he was—I cannot remember the exact words but his inference was that in fact not having a doctor there, there are some substantial benefits to that. That was my first point.

The second was, during our hearings I talked with Dr Rowan about his concerns—and again I am paraphrasing—but I asked him along the lines of, 'There is nothing in the legislation that stops the ombudsman from putting in place structures that would give comfort to the AMA,' and he agreed there was not. In fact during the minister's second reading speech the minister referred to that. I also want to make a point that the current Quality Health Complainants Commission in Queensland have a requirement to have consulting committees—one clinical; one based on consumer advocacy or consumers—but it does not require them to use their expertise but they do.

In practical terms, while I understand the concerns of the AMA and its sister organisations, I cannot subscribe to it because I see what is occurring in New South Wales. Many, many, many clinicians will identify that New South Wales have a very functional system and the mere fact of decisions being challenged will in itself be a check and balance to the ombudsman trying to be a the king pin jury everything without seeking further advice. In fact if a decision goes to QCAT around its rulings, then QCAT is actually required to bring in relevant knowledge to advise them on their decision. So I think there is a lot of check and balance capability in the legislation, and supporting legislation.

I guess that is where we came from; we just felt that there needs to be a flexibility and that there is nothing stopping an ombudsman from implementing structures to ensure that they have the adequate knowledge and reference points to make decisions from. My assessment based on our hearings with the New South Wales ombudsman is that the person actually needs to be an incredibly organised administrator as their primary function. I do not discount for a second the knowledge requirement, but that can be boosted seeking expert advice. If you had someone in the ombudsman who was not a well-organised manager, I think the whole thing has the potential to be not as effective as it is.

Just in reference to what the committee can request information on, the committee cannot request information about conciliation from the Health Ombudsman.

Mrs PEULICH—Thank you for that. Sorry, Mr Shuttleworth.

Mr SHUTTLEWORTH—My personal opinion just on AMA's concern around the appointment of a medical practitioner into that role, I mean from a fairly simplistic view point I guess but my view would be

that having someone in that position, they would feel within themselves that if they lacked sufficient knowledge to make that wholesome decision that they would be judging themselves and saying, 'Well, I'm kind of not up to the task. I shouldn't be seeking all this extra information.' Whereas someone who clearly is not a practitioner of medicine has to have that information provided to them. So rather than sort of I guess assessing something from a medical standpoint when they may not have the entire knowledge that would be required to really make a fair judgment, I think by having someone who is a lawyer and clearly needs to seek that information from a range of professionals rather than relying on him as himself/herself to make that sole judgment, I think it provides more robustness, more fairness to both the AMA, the practitioners who are being reviewed, and also to the public health outcomes.

THE CHAIR—I gather that is ultimately what the committee came to a conclusion on. We might move on. Ms Mikakos, thank you for that.

Ms MIKAKOS—Thank you very much for hosting us here at your parliament today.

Mr RUTHENBERG—You are very welcome.

Ms MIKAKOS—Just in relation to the committee's role to monitor and review the performance of the Health Ombudsman, what will be the key performance indicators that your committee will be using to measure their effectiveness.

Mr RUTHENBERG—The bottom line is, we do not know yet. Unfortunately our workload has been pretty huge but we will be going down that path early next year and we will be working with the minister to develop those so, as I said before, to make sure that we have got a consistent reporting structure that helps us to oversee those things. I would think that that will be part of our ongoing role, is to make sure we have got that somewhat right, to give us the capability to actually look down on those systemic processes to ensure that we are ending up with a fair process. I am sorry I cannot provide more than that for the—- -

Dr DOUGLAS—Could I add to that? I alluded to that earlier on, that in fact as a former chairman of the BCMC we used—I cannot tell you what they are—but you do measure certain things which are ongoing measures and you determine—for example, I could roughly sort of say numbers of investigations, numbers completed, where you are. It is possible that those sorts of things are the types of things that you would lean towards. The problem is, it is not so much the process of deciding what they will be; it is just it is limiting those things to those measures and actually saying, 'Well, that addresses the issue of the accountability.' In health you would understand one death of a mother is extremely important, and it is extremely important exactly all those tiny little bits; whereas when you are looking at it as a report it may not mean much because you are looking at the number of deliveries and comparing it. But in medicine it is the small details that make the difference.

It is not to say the committee would not do that but it may be in measuring certain things they are not reflective of really what is the broader agenda going on. It may well be that we have to evolve a set of measures that somehow capture all those things. I would think in an evolutionary way, I think that that is going to be difficult because there is no other current models globally of this model working and it is very different to what is going on in New South Wales, despite what is being said.

The CHAIR—Why did not you adopt the New South Wales model?

Mr O'BRIEN—In part they did. That is what I want to—I will get to that. You have gone to a state thing but go for it.

Mr RUTHENBERG—I guess that is really a policy focus but where the—I will refer back simply to the amount of consultation that was done leading into the drafting of the bill. Dr Cleary talked before—I cannot remember how many groups they spoke to—but they spoke to but they spoke to—and they covered all sorts of stakeholders, all sorts of people from consumers through to professional bodies and it was a consequence of that, plus the outcome of the three inquiries, that led to the bill we have and the New South Wales legislation was obviously seen to be lacking in certain areas. Suffice to say that when the New South Wales ombudsman spoke to us in the hearings he was very complimentary in his comments of the bill at that

time and that would be—I mean, I cannot give you specifics but it was the—

The CHAIR—It is the additional elements that you have put in place that distinguishes you from New South Wales.

Mr RUTHENBERG—It was the research that was done through all the consultation, plus the recommendations of the various inquiries that we ended up with this. Again, I will stand by that we spent an awful lot of time on this. We had very robust conversations privately as a committee and that is where we have ended up.

The CHAIR—Thank you for clarifying the additional elements that you've deemed was necessary. Mr O'Brien.

Mr O'BRIEN—Thank you again for your time. Sort of the core of the matter for me looking at the Victorian system is we have received a bit of evidence, which I think you have had as well, of some of the problems that have been occurring in the national system and the live question I suppose is, 'Why did you choose to in a sense follow the New South Wales system and move to a more state-based complaints system with a simplified procedure and what do you see as the benefits of your legislation to those earlier problems which I have identified you summarised at page 7?' Yes, they are mentioned in the Forrester report but I would like your evidence as the parliamentary committee identifying that particularly in relation to the legislation as to what you see will be the advantages of moving to the state-based model in the context of state-based medical systems.

Mr RUTHENBERG—If it is okay, I will, and then if it is okay, Madam Chair will let my colleagues speak also.

Mr O'BRIEN—Yes, please.

Mr RUTHENBERG—The bill is presented to us so as a committee we have no influence in its construction. However, when I take off my parliamentary hat and put on my corporate hat, I would say that the approach to the construction of this bill was very, very thorough. Typically in an organisation you will be presented with a problem and you will go about trying to work out how to identify what the root causes are of that and then how to address those root causes. That is in effect what was done here in the construct of the bill. The three inquiries identified problems, which was in effect our root cause analysis process. The department, through the minister's office, then went about trying to better understand what that is, put parameters around it and then put something in place to address that, and I think substantially that is what they did.

From my perspective, some of the issues we are looking at, for example, was in Queensland we had multiple places where complaints could come to and it was at the good will of the bodies working together that determined whether those complaints were being addressed adequately or not. We had circumstances where complaints were going six years without resolution and we have got circumstances where for whatever—there is multiple reasons—multiple committees over a period of time have had concerns with the way that this was occurring across Queensland. The three inquiries identified many of those issues that were in that system. I refer to our report on page 5, the chief executive of AHPRA, Mr Martin Fletcher, explained that AHPRA is not a complaints agency but essentially a productivity jurisdiction which focuses on addressing standards and concerns about health practitioners that concern patients and public safety.

The point of the ombudsman is that it will be a single place for complaint so the average person out on the street doesn't have to trawl over and try and discover a myriad of different points on whether their complaint goes to this place or this place or this place. They have got a single point of entry. The legislation puts around the time frames within which those have to be addressed. It also requires regular updates to the complainant. This substantial capacity now—if you go back to your person on the street who does not understand how the legislation works or necessarily how the complaint system works, you have now got a single point of contact and you will be updated on a regular basis.

What happens behind that is the substantial part of a bill. I think that that is probably—not probably—I am certain that that will be a significant benefit to Queensland because that will now be a singley managed focus

where the ombudsman is responsible for the outcome of complaints investigation, not the boards. It is the ombudsman, so there is a single point of contact for us and for the minister to oversee that. I think that is going to be incredibly important.

Mr O'BRIEN—Thank you.

Mr SHUTTLEWORTH—I would probably just add to that just by saying that how that is going to be measured would be quite difficult because I think that's largely an intangible benefit in that the public perception—they will know they feel better about it. They feel more comfortable with the complaints within the health system but they do not know exactly why. So how we measure that effectiveness I think will largely be from just a public perception, the public confidence in the level of complaint management within their health system.

Ms PEULICH—In addition to that, I would imagine you will have KPIs built around the very issues that have been identified as concerns: the delays, having it resolved locally, having it escalated to other levels and so forth. I think it is going to be—

Mr SHUTTLEWORTH—We will be able to substantiate those measures.

Ms PEULICH—Yes, absolutely.

Mr SHUTTLEWORTH—But from a public perception standpoint, they may understand exactly why it is better than it was.

Mrs PEULICH —The augmentation of any system when it comes to any processes is confounding to the public, so whilst I take on board Dr Douglas's comments about change of culture, throwing out the baby with the bath water, and certainly retaining the best features of a system because it takes usually a decade to bed it down, simplifying something as confounding as perhaps the fragmentation of a complaints system is something that I think would generally be embraced in particular say in our communities which has a much larger component of people from multicultural backgrounds who find it difficult to navigate the system as it is. I would commend I think the governance structures underpinning that and in particular I think the attempts to separate the dealing with complaints from the high order issues of registration and accreditation. I do not quite understand how the two entirely interface but it is something that I think has been a move in line with other governance reforms around the system. So well done.

But my question is this: if there were three bits of advice that you could give us Victorians—I would like to hear from each of you—what advice would you give us in terms of dealing with the issues that have been identified in terms of the existing national model and its sluggishness and the time delays and sort of the perceptions of people being disenfranchised by the system? What three bits of advice would you give us? Perhaps start off with the chairman and then—

Mr RUTHENBERG—Thank you. Look, the reason I became a politician was because I got sick and tired of some of the rubbish that I was faced with on a day-to-day basis. I love being in my electorate and I at one stage in my life was looking at becoming a pastor and for various reasons never did that. I have to tell you that I think I do more pastoral care now than I could have ever accomplished as a pastor. I make that statement because I think that we need to focus on our folks, our people, and the systems that were in place were simply not facilitating what I would consider to be defendable outcomes for people. Dr Douglas, you are right, the death of a baby, the death of a mother, while it may appear as a statistic when we are looking at a governance perspective, when I am back in my electorate, guess what, that is profoundly life changing to that family.

The streamlining of processes to ensure that we can properly determine whether there has been a systemic issue or a individual mistake made and determining how to address that, but also providing a level of comfort to the individuals I think, if nothing else, would give reason why we needed to move to something like this. When a person suffers loss, the processes of grief, eventually the are going to want to know why and we need to be able to provide that in a timely fashion, not six years down the track wondering what the heck has gone on.

The CHAIR—That is ultimately what you say, you need to get a far more efficient system in place and that is effectively what you believe this is doing.

Mr RUTHENBERG—The system had a whole heap of places where it was broken and my advice to you would be please make sure that you look at whether the system is benefiting or obstructing people on the ground. We are here to serve. Our job is to be brave enough to stand up and say, 'That thing is not working and how do we fix it?' Government systems work well. We, who are politicians, find the people where it does not work well for them, that is our job is to deal and help them work their way through finding solutions. When a system is pouring out lots and lots of problems far greater than what should be, it is time to have a look at it. My advice to you would be keep your focus on the people. My advice would be make sure that you use a robust framework to determine where you go from here.

I think, in this instance, the minister instructed a very robust framework without—I do not think there was a particular bias as to what he wanted to see come out of it. What he wanted to see come out of it was a fair system and allowed the people putting the bill together to go and talk to who they needed to talk to without fear or phobia and come up with a process that I think will serve Queensland very, very well.

The CHAIR—Okay. Mr Hathaway, have you got anything you would like to raise?

Mr HATHAWAY—Yes, thanks, Chair, just a few points. I think the key one that I took away from our inquiry was the one point of accountability and having that sole point of entry, that sole point of accountability because, remember, the ombudsman also has to hold AHPRA, which is the whole purpose of your inquiry, is my understanding, hold AHPRA's feet to the fire as well, but from a state basis we can put our hand on our heart and say, 'Ombudsman, what is going on?' So that was the key one, this one point.

The other thing was that I really do want to get away or get across to you is that it does not necessarily need to be prescriptive on the medical clinician point of view. I take that from my background as 30 years as an army officer and as commanding officer, I was not a doctor, but I was responsible for the health of 750 soldiers. As an army officer, I was not an investigator, but I had to do boards of inquiry and investigation. As an army officer, I was not a lawyer, yet I could also sentence people to terms of imprisonment. What did that mean to me? It meant that I needed to seek that information from those experts that we have in our system. You do not necessarily need to be expert in anything to run a system that is fairly all encompassing, you just need to know where to find the information.

The CHAIR—Thank you. Mr Shuttleworth.

Mr SHUTTLEWORTH—Yes, I would probably just back that up and just saying from a public perception standpoint, from a level of confidence in whatever you guys put forward, I think I actually—I see the independence of that commissioner, you know, against really what the AMA are saying, I actually think the level of public confidence in that role comes from not having doctors judge doctors but by doing—

The CHAIR—Okay, thank you. Dr Douglas, and I am coming back to you, Mr O'Brien, I know you do have a question you wanted to finish off and did not get a chance to, but Dr Douglas, if I could—

Dr DOUGLAS—I think that you have got to really find out exactly what it is about your own system that is the problem. You have got to know, you have got to independently ascertain what it is about your own system and you need to know exactly what that is, and you need to look at it, you know, not emotionally, and you need to quantify it as if to say: these are really what—these are the problems we have in our system in Victoria. Need to know—because what you are trying to do is locally face these, so you need to know exactly what that is in Victoria. Take all the other bits out of it because whatever you are going to propose has to be better than what you have already got, because if it is not any better, do not do it. That would be number 1.

Number 2, the existing model, if you are embracing—looking towards the ombudsman, and the only one that looks like it stood the test of time with state-based investigations is the New South Wales model. Despite, respectfully, what has been said today, he is clearly an administrator primarily and then there is the clinical reference committee drives really all the process where it needs it. They have a lot more authority. I understand, you know, lots of people in everyday life have this incredible reluctance about medical people,

investigating medical people, they have this idea that it is a club and a closed shop, it is not, it is not like that. It is a level of scrutiny that is different in other disciplines because we are judged differently and we inherently work in a different way.

People need not to be fearful of that because you place your trust in people like that and you have to because you have got to, and you would have experienced in your own life, so I would say that is an existing model issue to actively consider and the evidence globally would suggest that.

The third thing I would say is be transparent about processes. In other words, the problem with the AHPRA model currently is that unless it is referred to the tribunal, people do not know what the outcomes are if it is not known. It actually becomes a secret, and that is really what has happened with regards to that matter that I raised earlier on.

What you have got to try and do—and that is what should address a lot of the community angst—is there is no harm in telling people what is going on and you are not using the media then to terrify people unfairly, you are actually then informing them so they can make an informed decision. If you want to go forward, I would ask you to consider models whereby before it goes to a tribunal, processes that occur are made transparent. I mean, they have to be kept confidential, but there must be a point where they become transparent, and it will resolve a lot of the community angst that is—I mean, I am hearing it today from our own people. I think that is possibly what you have got, too. I think it is a global thing and I think it is probably a failing of our system. We do need to expose ourselves to people, you know, if we are going to have proper inquiries, proper investigations, we need to tell people what is actually transpired and we need to be not fearful of possible outcomes of it.

The CHAIR—Thank you, Mr O'Brien, do you want to finish off your—

Mr O'BRIEN—Yes, thanks, I would not mind an answer from Mr Hathaway and also Dr Douglas, and the key question for us in terms of coming up here for me, from my point of view, is this decision to go to a state-based complaints model. I have sort of got some answers but that is at the heart of the matter. The AMA had given us an indication that they—because the decisions on resource allocations are still essentially state-based within the health system, when you have the complaints system presently operating with AHPRA with perhaps a lack of transparency, and one of the examples was almost a carbon copy of an example that we have received evidence in relation to stall with our area of just no action and no notification, and the delays causing concerns with no-one able to step in because it is a legal matter or an investigatory matter.

What I would like to know very clearly from the three members who support the move to a state-based system, and your views, I am not sure what they are, I am happy to hear them, is what are the advantages of returning to a state-based complaint system or disadvantages, and why is that being pursued? Is it to do with—

The CHAIR—Okay. I think we have got Mr Hathaway.

Mr O'BRIEN—Yes, so Mr Hathaway and Dr Douglas.

Mr HATHAWAY—Alex, do you want to go first or me?

Dr DOUGLAS—Yes, look, every time you have got local—I do not think there is a major—originally I opposed it when it was proposed because I weighted the argument and said if the weighting of the argument is unfairly loaded in one thing on an emotional basis, it is for the wrong reason. The central investigative model had to be opposed because the evidence is that if you investigate locally, you have a greater chance of actually gathering information. Local based, actually, is weighted, wins on that argument.

Mr HATHAWAY—That is state based.

Dr DOUGLAS—State based. Remember, it is not an 80-20 rule with regards to the issues of individual complaints as opposed to—so the Pareto principle does not apply to complaints and it is actually 60-40. Individual complaints probably represent 60 per cent and 40 per cent is the systemic complaint. The systemic complaint is one that, really, you need to get on top of and possibly in a federal model the systemic

complaint is possibly better addressed. Unless you have got—facilitate linkages and increases in those, we would probably be able to give you a far better and more comprehensive answer on that, but you need to address the issue that systemic issues are significant, they are significant problems that may need to be addressed as well. Individual complaints possibly dealt with locally.

The third problem when you are looking at a state-based thing is timeliness. It is thought, and the evidence is, that within a local thing, that timeliness is better, but the history in Queensland is probably one that would probably not support that. But having said that, because timeliness was an issue with the previous board, okay, was an issue, but there are significant factors involved. The other thing is they would be using external investigators, and they did not have a very good process for doing so, and they were not also able to sometimes discriminate how they should use those people more to the corporate knowledge thing.

My view would be you need to consider those matters. If you propose a state-based mechanism, you need to make sure that you have the up linkages back into the system that give you the capacity either if you are not going to share information, which you should, and I would strongly endorse you should, but if you do not do that, that actually what you do do is you reference and then you work out mechanisms how you might interlink backwards, particularly systems at their cross dates and all that sort of stuff. I hope that answered the question.

The CHAIR—No, I have to move on.

Mr O'BRIEN—Yes, I know, I have got to get other answers, that is all.

The CHAIR—I know. Mr Hathaway, thank you, sorry to cut you off. Dr Douglas, did you want to say something finally?

Dr DOUGLAS—No, that is okay. My view would be: it does not really matter. Just as long as you take all that on board and you make sure that if you go to a state system, do not just decide you are not going to talk to the federal, you are going to brunt an exclusion, because you will fail and you will fail badly.

The CHAIR—Okay, thank you. Mr Hathaway.

Mr HATHAWAY—In fact, I will actually support Alex in part of that view, but ultimately I come back down to the sole point of accountability. I know whilst it is different in your system in trying to get AHPRA to speak to the fireys, is probably the key issue you are looking at, I think what the Queensland public look at, whilst we might treat New South Wales people or Victorians when they are up here, we are ultimately responsible at this parliament for the health of Queenslanders and people accessing our Queensland health system. I think that is where it comes down to, in my view, is the degree of comfort of making sure that we have enough controls over the investigative process.

The CHAIR—Thank you. I need to move to Ms Millar for a question.

Ms MILLAR—Yes, I am conscious of the time but I am also rather curious in terms of the importance that is been placed, for very obvious reasons, on the independence of the ombudsman, why the committee would elect to be interviewing and be very actively involved in the recruitment process, and also touching back on Ms Mikakos's point. Again, in terms of the independence of the role and the setting of KPIs, why the setting of KPIs would not be done ahead of the recruitment process to ensure that there is that hands-off, arms length relationship between the ombudsman and this committee.

Mr RUTHENBERG—Good question. I guess the first point is that the regulation and the relevant parts of that Act just have not yet commenced. First part. Secondly—

Mr SHUTTLEWORTH—Sorry, I think, too, the first part included why are we interviewing—I do not believe we are actually interviewing; we are reviewing the submissions.

Ms MILLAR—I think the chairman made the point of saying that you have asked for the CVs of the short-listed candidates.

Mr RUTHENBERG—Correct. The process that we have agreed to, as I said, we will get the CVs and the short list, and give our opinion to the minister. I do not see it as a conflict because we have oversight. I think a conflict would be that if one of us was involved in the actual interviews and the appointment is made—I think this is right—is made by the ministers through Governor in Council. The appointment is made through Governor in Council. The actual appointment is not the committee's responsibility. However, the committee has an opportunity to speak into that point. It provides that fairly robust—and at the first instance, it may seem there are a few things we need to deal with, and you are right, but going on from past that, it will become far more robust.

Mrs PEULICH—It is not unusual for key committees to be consulted on key appointments such as, for example, the Public Accounts and Estimates Committee and consultations that typically occur surrounding the appointment of the Auditor-General because all party committees obviously have the opportunity to be consulted and therefore depoliticised or—

Mr RUTHENBERG—We actually had an incredibly robust conversation about this and our secretary provided us with the multiple role or examples of the multiple roles of how different statutory authorities are appointed, and this is where we ended up, and needless to the say the non-government members and government members did not come eye to eye on this one. The non-government members wanted actually to have veto capacity and we felt that would be far more of an overstep rather than—and I understand—I understood where they are coming from, I just felt, and the government members felt, that just was not going to be conducive in the long-term, but that since the minister was responsible, the minister should have that capacity on authority.

The CHAIR—Yes, sorry, keep going.

Mr RUTHENBERG—Again the transition processes are in place and the fullness of how the ombudsman wants to set up their organisation will be within the ombudsman's authority. Once we understand what that looks like and what those structures are, and what the outcome requirements are, et cetera, then we will be able to work with the minister to try and come up with what will be, hopefully, holistic reporting. Like all reporting, you want to be able to have the confidence that you can drill down into and find any specific issues and situations.

The CHAIR—Any further questions?

Ms MILLAR—No. Well, really just in terms of the timing of when you set the KPIs, I just felt it would have been useful to do it up front and that would be possibly useful information to the candidates themselves as to what they would be accountable for, but also just in terms of the timelines, that it is seen as being totally independent of anyone individual, that the KPIs are set, this is what they are.

Mr RUTHENBERG—The legislation provides for certain outcomes but gives the ombudsman flexibility to arrive there. I would hate to be trying to draw that road map for them. I think it is important that the ombudsman be able to maintain the independence of determining how they do that themselves. Our job then would be to come along, say, 'All right, you have got that road map set up, where are the sign posts that we need?'

The CHAIR—Unfortunately, I think we are out of time. This has been very enlightening for our committee. I note that you are an all party committee and that some of your members are not present today, but we very much appreciate your attendance and the evidence that you have provided to us, and the engagement, and we are very appreciative of that, and also for hosting us. Would you pass on your thanks to your colleagues. It is been most helpful On behalf of our committee, thank you very much indeed.

Mr RUTHENBERG—Thank you.

Witnesses withdrew.

Hearing suspended.

PROOF VERSION ONLY

LEGAL AND SOCIAL ISSUES LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Brisbane—22 November 2013

Members

Ms G. Crozier
Mrs I. Peulich
Mr D. O'Brien
Ms A. Millar
Ms J. Mikakos

Chair: Ms G. Crozier

Staff

Senior Secretary: Richard Willis

Witness

Bond University:

Dr K. Forrester, Associate Professor, Faculty of Health Sciences and Medicine.

NECESSARY CORRECTIONS TO BE NOTIFIED TO SECRETARY OF COMMITTEE

The CHAIR—Thank you very much. We have before us Dr Kim Forrester, associate professor, Faculty of Health Sciences and Medicine at Bond University. Thank you for being before us, it is a pleasure to conduct these hearings here in Brisbane and we do appreciate your time this afternoon. We have a particular focus on the health complaint system, recent developments in this state to create a Health Ombudsman, and that is related to the National Registration and Accreditation Scheme for Health Practitioners. All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Victorian Constitution Act 1975, and further subject to the provisions of the Victorian Parliament Legislative Council of Standing Orders, The parliament of Victoria's Parliamentary Committees Act 2003 and the Deformation Act 2005, and, where applicable, provisions of reciprocal legislation of Australian states and territories.

All evidence is being recorded and you will be provided with a proofed version of the transcript in coming days. I do not know if you have got a statement that you would like to make to us or have some material, but we would be very keen to understand a little bit about the findings in your report and how that came about, if you would be prepared to—

Dr FORRESTER—Absolutely. I did not prepare—

The CHAIR—Give us an overview.

Dr FORRESTER—I thought it may be of greater assistance for you to ask me what you wanted to know. As you will be aware, we started off with about just under 2,500 files for the period we were looking at. In relation to what was in scope, it came down to 596. There were in that 596 a number of legacy files, so they were files that were open prior to the transition on 1 July 2010 which were transitioned across under the national scheme, and then the remainder were non-legacy files.

We looked at the timeliness of decisions, so we looked at the time between the notification and the assessment meeting, and then the time from the assessment meeting to the appointment of an investigator, the time the investigation took and then the final time, so overall from time of notification to the time of the final decision, and we looked at the non-legacy and legacy files separately. I suppose addressing that issue, it has to be said that out of the number, the 596, and I think it is in the report the number that we then discounted as having been dealt with in an appropriate and timely manner, that left about, I think, 363 in the report that we actually considered under legacy and non-legacy.

I suppose issue number one that I think is significant is that there would be, literally over that period of time millions of contacts between medical practitioners and patients in Queensland, so I think it is important to actually see the files in the sort of perspective of the total number of contacts between medical practitioners and patients and clients. The other issue, I think, is it is clear from the files in scope that the legacy files, the ones that transitioned across, there were more of those than there were the non-legacy files, so it was trending in the right direction after the transition but incredibly slow.

I just think it is important to put that in some kind of perspective. We dealt with, as I said, the legacy files, the ones that transitioned across, and the non-legacy files separately. In relation to the timeliness, you will have seen from the report the length of time that a complaint once lodged was in the process having been lodged but prior to assessment was quite long in a high proportion of non-legacy and legacy cases, and then there was also an inordinately long period between the decision to appoint an investigator and to conduct an investigation.

I think that for both legacy and non-legacy, the issue there in relation to the recommendation two, which was for the panel to make a decision about the protection of the public under the legislation, was that during that period of time there is no assessment of competency, there is no monitoring, there is no supervision, literally nothing is happening during that period of time, so the complainant has lodged a complaint and then in some circumstances they were waiting several months and years for an assessment to be made as to whether the complaint was going to be moved through the process or whether in fact it was going to be, you know, a decision was made not to proceed, and that is then compounded, it was compounded in the view of the panel by the next length of time between appointing an investigator and now the investigation is commencing and the length of time the investigation actually took.

For that period of time, practitioners are out in the public and conducting their practice without there being really any assessment of their competency to practice, and I think at the heart of both the review of the files in relation to timeliness and appropriateness this issue of whether there is an assessment of the practitioner's competency to practice very rarely was, I think, put forward. The files would indicate that there was no indication of what was happening there over that period of time. In relation to—

Mr O'BRIEN—Wow.

Dr FORRESTER—Sorry, I beg your pardon?

Mr O'BRIEN—I said, 'Wow,' I am sorry. I do not want to interrupt, but what are the reasons why there was such a delay in making an assessment or pointing out an assessment?

Dr FORRESTER—Well, that has to be the process, that has to be the process of AHPRA and the board were engaged in, so it was a process issue. The time between notification, appointment, appointment and conducting time to conduct in the files that we looked at was very, very rarely correlated with the significance of the—

The CHAIR—Severity of the cases.

Dr FORRESTER—Yes. The nature of the allegations, the source of the allegations, so as an example, even where the notification had been made by the Coroner or had been made by a public hospital, so Queensland Health or the private sector, who had already conducted investigations, the notification was processed in exactly the same way as if it had been made by a member of the public. There was no ability—

The CHAIR—It is not a priority.

Dr FORRESTER—There was no ability to expedite that process. In relation to the length of time the investigations took, it was clear in a number of the files both legacy and non-legacy that several investigators may be involved and so clearly, the process has sort of halted at that point. The co-referral or jurisdictional issues between the medical board, AHPRA, and the Health Quality and Complaints Commission also stalled the process, so the Health Practitioners Professional Standards Act and the Health Quality and Complaints Commission Act provided for a co-referral in terms of where complaints were actually lodged, and that was continued on under the National Law Act.

It was not as if the National Law Act then had an impact on that, you still had a position where a complaint would be made to the HQCC and then they would be required to refer it to the board, or a complaint would be made to AHPRA and the board, and there was a requirement under the legislation about it to be referred to the HQCC. You had files sitting in these two entities waiting for one or either in the process to make a decision that it could be referred back to the board, as an example. In some circumstances, a decision was not made, that files were being sought from the HQCC which had been referred by the board but were sitting in the HQCC process not coming back to the board, or the HQCC would make a decision based on their experts that in fact there was grounds for unsatisfactory professional performance or professional misconduct, but it would go to the board and the board would make a decision that in fact that was not really—

The CHAIR—What was their reason for that process, for them to conduct that process?

Dr FORRESTER—It was legislatively determined, so the Health Quality and Complaints Commission Act and the Health Practitioners Professional Standards Act had provisions that required this reciprocal arrangement in relation to if it was a health service complaint—

The CHAIR—Cross agency referral.

Dr FORRESTER—That is right. There was this co-jurisdictional requirement under the legislation, and if you look at the National Law Act that continued under that piece of legislation. That in itself created a number of problems not only in relation to the length of time that it was traversing with the complaints, and notifications were traversing the process, but you had files in which the HQCC expert would make a decision

that there were grounds and therefore it would be referred to the medical board, and the medical board would form the view that on their expert opinion there were not grounds and it would be a no further action or that they were not going to take it. The board would make the decision they were not going to take the referral back because, in their opinion, there was not substance to the complaint.

The CHAIR—In that case, then, so was that file closed and dealt with or did the medical board still have that file on their books, so to speak?

Dr FORRESTER—If it came back to the medical board, it would in most circumstances be a not for further action, so either the board, with or without an investigation, would say that there was no substance for the complaint and it would be a no further action. If you look at the appropriate—

The CHAIR—But that is quite reasonable in some instances, is it not?

Dr FORRESTER—The panel formed the view that if the Health Quality and Complaints Commission had dealt with a complaint and it had a clinical expert give an opinion that in fact there were grounds upon which, you know, there could be a finding of unsatisfactory professional conduct or professional misconduct and referred it to the board, that it would have been in terms of protecting the public, I suppose, advisable for them to have conducted their own investigation or to have sought their own clinical experts to make a decision as to whether in fact this should have been pursued, but in a significant proportion of the matters that came across the board made a decision they were for no further action.

If you look through the report, in a number of instances just in some of the files that we identify, the reasons for the decision may say something like, 'There are grounds for a finding of unsatisfactory professional performance,' but the decision is NFA.

The CHAIR—They have acknowledged it but they are not taking any further action.

Dr FORRESTER—The panel was of the view that in terms of the obligation to protect the public that there had been in a number of circumstances, no assessment of whether this person had capacity or competency to practice because the matter had come across and then a decision had been made, or the decision may be made on the basis of requesting a submission, so it would come from the HQCC to the board, a request would be made for a submission from a medical practitioner and that submission would address a number of issues which usually said things like, you know, 'I recognise that this has been a problem, but I am going to do a course,' or, 'I will make sure this does not happen again,' and then the board would make a decision for no further action.

It did seem to the panel, without wanting to be flippant about that, that is clearly what you would say. You are hardly going to address a submission by saying, 'Yes, that is very poor indeed and somebody might need to do something about that.' Our view was that in many ways the system, as it had previously been, was really focused on punitive as opposed to protection. The process itself appeared, based on the files that we examined, to have a focus on whether punitive action was or was not appropriate as opposed to, 'What do we need to do here to make some kind of assessment as to whether this practitioner is competent and safe to practice?' Very few of the files on the graphs and tables that you have, very few of them went to the supervision, conditions, limitations sections of the pie graphs.

Mrs PEULICH—Is that a product of a peer review model that is adopted?

Dr FORRESTER—Well, the minutes of the decisions do not spell that out, but the view of the panel would certainly have been leaning in the direction of the board making a decision as to whether this punitive outcome was in fact cognisant with the action as opposed to, 'We have the action, and what do we need to do to make an assessment as to whether this person is competent to practise?' It did seem to us that was unusual, particularly in relation to medical practice where medical schools and, you know, as an example, Mark O'Brien, here with the Cognitive Institute.

You know, the OSCIs—there are medical schools and the specialist colleges all have systems for assessing competency to practice of medical practitioners, so it is not as if there would be a requirement to generate a

whole new infrastructure of making a decision as to whether you, a surgeon or an obstetrician or an orthopod, were competent to practice. The specialist college already has a whole framework which is directed to making those assessments.

Mrs PEULICH—We heard from an earlier witness of the collaborative model, if it is used by medical practitioners in making decisions, do you think that is reflected in the manner in which investigations may have been undertaken or somehow rather than someone making a final decision that this is the chop, this is what has got to happen following appropriate investigations. Do you think that might be a product of peers reviewing their own colleagues in their own profession?

Dr FORRESTER—There was nothing in the minutes that I could say objectively that was the view we formed, and I think also that question highlights in relation to the investigations—the investigations that were in the main were really very well—they were well done, they took a very long time, an inordinately long time and in many circumstances not commensurate with the clinical significance or even the difficulty of them, but some of them are quite simple, but they were well done and unbiased and they brought back recommendations to the board, so the recommendation of the investigation report would be tabled with the board document.

In a significant percentage of them, the recommendation of the investigator was there were grounds upon which the board would be able to form a view that, you know, this should lead to disciplinary outcomes, and then the board would make a decision either not for action, and if discipline by correspondence, which actually does not exist now under the new legislation, or a show cause caution or just a caution, which one of those outcomes—getting back to where I was before—a show cause caution, a caution, a discipline by correspondence, none of that is directed to making an assessment as to whether this person is competent to practice. It in no way gives you any idea of whether this person is actually going to be safe in their practice.

The CHAIR—Thank you. Ms Mikakos.

Ms MIKAKOS—Thank you very much for your presentation. I was interested in your comment before when you said the focus in the files was on a punitive rather than a prevention approach, I think is the way you put it. I know you had a fairly narrow terms of reference in terms of what you were asked to look at, but, as I understand it, the Health Quality and Complaints Commission had two roles: one was to investigate complaints but one was also to look at quality assurance issues.

Dr FORRESTER—Yes.

Ms MIKAKOS—I do not believe that particular function is actually being—the quality assurance function is being transferred now to the new proposed Health Ombudsman, as I understand it. Do you have any comments to make around the importance of quality assurance and, as you said, the need to focus on prevention rather than cure?

Dr FORRESTER—I can put it in this context. For three years I sat on the Health Quality and Complaints Commission as Assistant Commissioner; Legal, so from 2006 to 2009 I was quite familiar with the work of the HQCC particularly in relation to quality and the standards and monitoring throughout the state and my view is that your reading of the new act in terms of that quality assurance framework role is probably correct however the new legislation, as I read it, effectively gives the Health Ombudsman a power in relation to the quality of health services to investigate and conduct inquiries in relation to the quality of health services, so as the legislation has been recently introduced and the Health Ombudsman has not been appointed, but under the functions and roles of the Health Ombudsman under that act, as I read the act, there is an ability for the Health Ombudsman to conduct investigations and inquiries in relation to quality matters that are derived from some kind of systemic issue and that, as I would read the legislation, is able to be activated even without a complaint, so if the Health Ombudsman becomes aware that there is some quality or systemic issue there is an ability under the provisions of the act to actually investigate and inquire into that, but I agree it is not as clear and as a separate role as it is set out under the HQCC Act, yes, I would agree with that.

Ms MIKAKOS—It seems as though there has been a downgraded function really of the new Health Ombudsman.

Dr FORRESTER—It may well depend on whether the Health Ombudsman makes a decision in terms of the structure of the Health Ombudsman's office to create a part of the structure to deal with that in time, but I agree with you, under the HQCC Act it was a very clear legislative provision. The quality of health services and monitoring was definitely an objective of that act though I do not think—from my reading of the act I think it is not correct to say that that role has now been disbanded. It will I think rely on the Health Ombudsman's office and the Health Ombudsman making a decision as to whether they ought create that as a separate sort of unit or even integrate in to compliance.

Ms MIKAKOS—It will presumably require resources and, as I understand it, the funding is coming from shifting funding that would have gone to AHPRA for investigations and complaints to the new Health Ombudsman, that resources probably are not there unless the government puts in—I do not want to put you in a difficult position to comment on these issues, but—

Dr FORRESTER—I am not in a position to comment on that, on funding.

Ms MIKAKOS—Yes, it appears to me to have become a downgraded function—

The CHAIR—Can I just ask just for clarification in relation to that?

Dr FORRESTER—Yes.

The CHAIR—There is the additional monitoring with the committees powers too—

Dr FORRESTER—Yes.

The CHAIR—I suppose that is one area that QA, even though it is not a separate function, but there are multiple bodies that can oversee that quality assurance component. Is that—

Dr FORRESTER—Yes, that is correct, so the legislation clearly places the health and community services committee and the minister in a position in relation to reports and being able to require investigations and inquiries, so the health and community services committee and the minister who would oversee that under the legislation, certainly the provisions would provide for that, yes.

The CHAIR—You have got a further question, Mr O'Brien?

Mr O'BRIEN—Thank you, Chair. Yes, one thing I would like to focus on in terms of the situation prior to the national scheme, and you have touched on that and then as identified in your report and the other reports, and now where the legislation is heading is the decisions to have the complaints and notification system in a national scheme or within a state scheme.

Dr FORRESTER—Yes.

Mr O'BRIEN—In broad compass you have got New South Wales who have maintained a state scheme and you have got Queensland who is heading to one. In terms of some of the problems that I think you identified, I am quoting the Parliamentary Committee summary of your report which talked about considerable delays and inconsistencies in a number of significant files due to cross jurisdictional referral, consultation and information sharing obligations imposed under the current legislation and you gave us some insight into that with the sort of time taken to derive those initial assessments. Are you able to provide us with your views on I suppose the advantages or reasons for the decision behind the legislation to go to a state based system and what your thoughts about that.

Dr FORRESTER—The impact of the Health Ombudsman Act as I read it is to amend the application of the national laws and it amends the application in the form that the Health Ombudsman becomes a single entry point for health complaints and the management of those complaints.

One of the issues I think that was evident in our report was that there was or there appeared to be in the files

we reviewed a very poor case management structure, if there was one at all, where the system under the new legislation, under the Health Ombudsman Act, as I would read it, clearly defines the power of the Health Ombudsman in relation to a single entry point and then there are time mechanisms which are in the legislation, so seven days to make a decision as to whether accepting or rejecting; 30 days to make an assessment; one year for the investigation; 14 days to respond in submission, so it would appear that from the reading of the legislation that the case management of complaints under the Health Ombudsman Act is going to be much tighter and it will be more transparent than it has been under the previous system but that, as I said, would only—that is my view on the basis of the files that we reviewed.

Mr O'BRIEN—Yes. A factor that was identified as I understood the evidence in a way—and you were not here, but I will try and do my best—from the AMA or the Queensland AMA was that particularly in regional areas which we are concerned about where there is a complaint made against a practitioner can also have service or effectively takes away a service from a regional area, obstetrics or something, if that is the only surgeon qualified in an area and so the consequences of these delays, if there are delays, to the system, obviously to the health and the opportunities for health in those regional areas particularly can be quite grave and if I take it that was a suggestion of why a state based complaint system might be more nimble or more robust. Is that something that you are able to comment on or was picked up in your report?

Dr FORRESTER—I think a system which is based on the Health Ombudsman Act, so for serious matters and there is still an ability for the Health Ombudsman in matters which are not considered under the act to be serious for those to be forwarded to the national system, but I think that a system that is set out under the Health Ombudsman Act then clearly becomes a system which is more manageable within a state based system, so that as I said, you are case managing; the timelines are clear; you are able to identify where that complaint is in the process. There is an obligation for the Health Ombudsman to be notifying the complainant and the registrant as to what is actually going on, so that the process itself is more contained, that has to be an advantage.

Mr O'BRIEN—Yes, okay, thank you.

The CHAIR—Mrs Peulich.

Mrs PEULICH—Notwithstanding the fact that implementation is still happening and obviously there has been a lot of work been done at every stage to try and make the system work.

Dr FORRESTER—Yes.

Mrs PEULICH—The reforms addressed the concerns that have been identified and fairly graphically by you in terms of the files that you have examined. Obviously you cannot impact the implementation, but conceptually does the system, does the reform introduced by this legislation address the major concerns that have been identified? Do you see that as an adequate or an effective response?

Dr FORRESTER—I think that—

Mrs PEULICH—And where to from here?

Dr FORRESTER—Goodness, I do not know that I have the answer to that last—we will see how we go with what we have. My view is that the legislation is a very real and practical attempt to address the issues that were raised in relation to Mr Chesterman's report and in relation to Mr Hunter's report and the report I did with Prof Davies and Dr Houston, so I think that in reading that legislation it does appear to me that every attempt has been made to adopt the recommendations where possible.

In terms of where it would move from here I think it remains to be seen how we progress, so implementing legislation and the roles that are identified so the Health Ombudsman and the director of proceedings and the role of the consumer and clinical panels and committees, all of those processes and the timelines. The requirement under the legislation for the information to be made available to the public and to the parties clearly seems to address what we found in the files that we reviewed.

One of the issues that I think has been addressed and will be of great assistance is where complaints are made and they are in the process that not only the complainant does not know what is happening, but the registrant does not know either.

Mrs PEULICH—The transition—

Dr FORRESTER—Yes, and I think that in some of the more exceptional ones, just to illustrate the point, it is not only the complainant who was waiting for several years to know where the complaint was in the process, but you also had a medical practitioner attempting to conduct their practice and also live their life with a complaint that may have been sitting there for three, four, five years, so under the new legislation clearly every three months both parties are going to know exactly where it is in the process and I think that has to be a benefit.

Mrs PEULICH—Yes.

The CHAIR—Thank you. Ms Millar.

Ms MILLAR—Yes, Dr Forrester, I am just interested in your view. We had a meeting with the AMA earlier today and they did express some concerns that legislation does not mandate for the ombudsman to seek clinical input into decisions.

Dr FORRESTER—Yes.

Ms MILLAR—Do you have a view on that and did anything in your report address that specifically?

Dr FORRESTER—Our report did not address that specifically and there was nothing in our recommendations about that other than making a recommendation in terms of the composition of the boards if they were to continue in their form.

The legislation as I would read it provides that the Health Ombudsman is able to seek the assistance and information from consumer and clinical panels. My reading of that is that it would operate almost in the same way that the QCAT has professional assessors, so it does seem to me that to put the Health Ombudsman in a position where it is mandatory to seek clinical sort of assistance starts to go back to being bogged down again in terms—so if you are presuming that the person appointed to be the Health Ombudsman is able to comply appropriately with the legislative requirements it seems to me that it would follow on that that person would of necessity be able to make decisions about when they assumed they required some kind of clinical or consumer assistance in making a decision and if a decision is made, as an example, an immediate action and the view of the practitioner, is it is not appropriate, then there is ability to appeal that decision to the QCAT.

Ms MILLAR—Thank you, that is helpful.

The CHAIR—I know your terms of reference were quite specific—

Dr FORRESTER—Yes.

The CHAIR—This next question might be slightly out of your remit but did this come into consideration with you and the panel in relation to the minister, of the state's responsibilities? Ultimately they have responsibility for the health services within the state and under the national scheme it appears to me that they do not have very much control or they are disempowered from their ability to have some authority and accountability to exactly the issues that you raise. Did that come into consideration in relation to what you were looking at about how the minister should either act or not act?

Dr FORRESTER—No. We were within the terms of reference of recommendation 2 of Mr Chesterman—

The CHAIR—Yes.

Dr FORRESTER—That is exactly what we did and so the role of the minister was not in any way involved in that—

The CHAIR—No, so you are unable to say.

Dr FORRESTER—I would not be able to comment on that.

The CHAIR—No, that is fine, thank you. Mr O'Brien, do you—

Mr O'BRIEN—Just if you could just elaborate a bit more on the problems you identified with—in the report it says 'consistency and predictability of outcomes in the boards decisions across notifications of a similar nature'.

Dr FORRESTER—Yes.

Mr O'BRIEN—Could you just outline some of the problems that you found there and perhaps why they were and what you think may help solve them?

Dr FORRESTER—In relation to appropriateness of outcome we looked at them under categories, so you will see there is a category for missed diagnosis and misdiagnosis and there is a category for official misconduct and boundary violations and prescribing errors and poor medical and surgical outcomes. We looked at those to attempt to identify whether in relation to that there was any kind of consistency or predictability in the outcome, so where the allegations were of a similar nature was there an ability to be able to predict what the likely outcome was and what we found across almost all of those categories that there was very little predictability or consistency in outcome and so where allegations were similar there was not a consistent outcome.

One of the things that we addressed in the recommendations in relation to that is that there should be a de-identified publication of outcomes in relation to matters that came before the disciplinary tribunals and before the board at the time and that those decisions should be considered in making decisions as to what was going to happen in relation to this matter and I think there are two benefits in that. The first one is that it does give you predictability of outcome, but it also then serves as an educational tool for clinicians to be able to get a very clear idea, 'If I participate in this conduct here this is likely to be the outcome', so it not only is a tool in relation to protection of the public, but it means that the process is clearly predictable, transparent and consistent and if you—just looking at the examples in relation to those categories it becomes fairly clear that that was not the case and why the board would make those decisions was very unclear on the minutes of the files.

Mr O'BRIEN—Could I just clarify was that inconsistency say within a medical group even within this diagnosis, so two surgeons with misdiagnosis might get different outcomes, or was it across the profession?

Dr FORRESTER—We only looked at medical practitioners—

Mr O'BRIEN—Okay.

Dr FORRESTER—If you look at, as an example, the misdiagnosis or missed diagnosis where there were allegations and investigation findings that were similar there could be quite disparate outcomes to that. The greatest consistency in relation to outcomes were in relation to, as I recall, the prescribing—the allegations in relation to medications and prescriptions and the panel formed the view that there is a clear—under the Health (Drugs and Poisons) Regulations it is very clear what is expected there, so those decisions and the decisions in relation to boundary violations, that were based in some kind of sexual misconduct allegation, they seemed to be clearer and more predictable and consistent with the complaint, but in relation to the other three or four there was a very clear lack of consistency and lack of predictability and that is why we actually did it by categories because we were not sure initially if that is what we were looking at because it seemed so unusual.

Mr O'BRIEN—Just on that I asked a similar question to the department, they indicated I think in relatively recent times, I am not sure where it fits in the chronology of what you looked at, there was developed a precedent system which sounds a bit similar to where you were saying—did you have a look at that or was that something that was not—

Dr FORRESTER—No. The files that we looked at were the ones closed by 30 June 2012—

Mr O'BRIEN—Okay.

Dr FORRESTER—Those were still ongoing which is why the 2012 data looks different from the preceding data because those were complaints that were made in 2012, but continued to be open and so they were not in scope and the—I think what you are describing was after 2012, so it was not within the scope.

Mrs PEULICH—I know obviously it may not have been your terms of reference, but in terms of explaining the disparity in outcomes of similar complaints what can you attribute that to—different investigators or a degree of subjectivity that perhaps was not managed appropriately by some sort of more concrete parameters?

Dr FORRESTER—The panel discussed that issue at length and in the recommendations I think is reflected in the points that say it is highly desirable to have the boards made up of high numbers of multidisciplinary members, to have high numbers of consumers and probably to have the decision-maker not be from the discipline, so it was not clear how those decisions were made. What was clear was that even in reading the minutes and the reasons for decisions the decision did not reflect the discussion of the preceding pages, so how the actual decision was made was frequently not clear because it did look as if the recommendations from the investigation and even on the boards own reasons for decision that there were grounds for some form of disciplinary action and yet the decision would be—

The CHAIR—Just a point of clarity in terms of the composition you are saying that there should be large numbers. Is that what you say?

Dr FORRESTER—No. There should be, a recommendation was, a greater mix of—

The CHAIR—Greater mix, I beg your pardon.

Dr FORRESTER—Yes, not larger numbers but a greater mix.

The CHAIR—Yes.

Dr FORRESTER—I think that from the public protection or the perception of public protection and the actual public protection that it needs to be independent and impartial and that needs to be not only done but seen to be done and I think that that is an important issue and it was certainly an important issue that came out of the findings.

The CHAIR—But to have the clinical input as part of that?

Dr FORRESTER—Yes. We certainly would not be suggesting that there was not a clinical component. We definitely were not suggesting that, no.

The CHAIR—Yes. Mr O'Brien.

Mr O'BRIEN—Just on the clinical component because that may be at the heart of some of this as well. Obviously within certain specialities—all medicine is very specialised, but in some it is even more specialised and there can be legitimate differences of opinion within the profession. Now, as I understand the system that is a role of the colleges to generally sought out, but some of the actions and the differences may only emerge in a singular case about whether there was malpractice and then you get the introduction of expert witnesses and maybe paid professionals and the whole litigious process which often involves a hands off from everyone else who may have an interest input because it is natural justice rights or before the court

and that may support a justification of a delineation between the governance or the role of the colleges in the setting the standards and the sort of enforcement or complaints mechanisms involving the practitioners, but does it also require greater accountability within the medical profession of the acceptance of and resolution of legitimate differences in medical opinion?

Dr FORRESTER—I think I would not be able to answer that. I think that is well outside the terms of reference of the review. I think that I would not be able to answer that fully.

Mr O'BRIEN—Just on a specific thing if we are looking at a complaint and it raises best practice issues, how to treat a particular operation how is that presently resolved? Is it resolved on the facts and left to that complaint or do the colleges step in and say, 'Well, there's a New Zealand method here that is now the world's best practice, we better adopt that'?

Dr FORRESTER—My understanding is that that would be done on a case by case basis and I would not really be able to comment on that in terms of a definitive answer of how—

Mrs PEULICH—In view of that is it then wise in terms of governance to give the ombudsman some flexibility in how to draw on that expert evidence—

Dr FORRESTER—Yes.

Mrs PEULICH—Because in actual fact with break through medicine and technology and so forth perhaps that expert input can be found in slightly more remote locations if you know what I mean.

Dr FORRESTER—Yes.

Mrs PEULICH—Do you think that that is an appropriate thing in the bill or do you think that it ought to be mandated?

Dr FORRESTER—No, I think that it is appropriate. I think it gives the Health Ombudsman Act—the provisions provide that the Health Ombudsman can seek clinical or consumer advice as a complaint presents itself and my reading of the legislation is that that is not limited. It is not limited in terms of seeking advice from any clinical speciality and I mean clearly there is a recognition that medical technology and medicine is constantly progressing and changing, so it does give an ability of the Health Ombudsman to be able to say, 'Well, in these circumstances I need clinical advice from these clinicians as to what we should do for immediate action, whether this is appropriate or not'.

The CHAIR—Yes, okay. Thank you for that. Any more questions?

Mrs PEULICH—No.

The CHAIR—Thank you very much indeed.

Dr FORRESTER—Thank you.

The CHAIR—Can I, on behalf of the committee, thank you again for taking the time and being before us this afternoon. We do appreciate it and we very much value the input that you have given to us, so thank you.

Dr FORRESTER—Thank you very much.

Mr O'BRIEN—Thank you for your time.

The CHAIR—Thank you.

Dr FORRESTER—Thank you. Would you mind if I stay? Is that—

The CHAIR—No, of course not.

Dr FORRESTER—Thank you.

Witness withdrew.

Hearing suspended.

PROOF VERSION ONLY

LEGAL AND SOCIAL ISSUES LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Brisbane—22 November 2013

Members

Ms G. Crozier
Mrs I. Peulich
Mr D. O'Brien
Ms A. Millar
Ms J. Mikakos

Chair: Ms G. Crozier

Staff

Senior Secretary: Richard Willis

Witnesses

Australian Health Practitioner Regulation Agency, Queensland:

Mr C. Robertson, Director, National Boards Queensland; and

Mr M. Hardy, Director, Regulatory Operations.

Queensland Medical Interim Notifications Group:

Ms S. Gallagher, Chair; and

Dr M. Waters, Practitioner and Member.

NECESSARY CORRECTIONS TO BE NOTIFIED TO SECRETARY OF COMMITTEE

The CHAIR—Thank you all very much for being before us this afternoon and I welcome Mr Chris Robertson, Director National Boards Queensland from AHPRA; Ms Stephanie Gallagher, Chair Queensland Medical Interim Notifications Group; Mr Matthew Hardy, Director of Regulatory Operations from AHPRA; and Dr Mark Waters, Practitioner, member Queensland Medical Interim Notifications Group.

As you are aware we are here with a particular focus on the health complaint system and recent developments in this state to create a Health Ombudsman and those matters related to the National Registration and Accreditation Scheme for health practitioners.

All evidence taken at this hearing is protected by the parliamentary privilege as provided by the Victorian Constitution Act 1975 and further subject to the provisions of the Victorian Parliament Legislative Council Standing Orders, the Parliament of Victoria's Parliamentary Committees Act 2003 and the Defamation Act 2005 and where applicable the provisions of reciprocal legislation of Australian states and territories. All evidence is being recorded and we will provide you a transcript of the approved version within the next week.

I again thank you very much for your time to be before us. Mr Robertson, if you would like to make a few comments in relation to AHPRA we would be very welcoming of those and then I might open up to members or give other members some opportunity to also speak and then open up to members to ask questions.

Mr ROBERTSON—Thank you very much. Thank you for the opportunity to address you today. I am very conscious that AHPRA and a number of the national board chairs have previously spoken to you and we have a submission that has been provided and I understand that there are some scheduled further submissions that will be happening over the next two weeks I think.

The CHAIR—That is correct. We have AHPRA coming back in a month's time roughly.

Mr O'BRIEN—The Victorian Board next Wednesday and AHPRA on the 11th.

The CHAIR—11 December.

Mr ROBERTSON—Yes. I think our comments are in that context. However, the opportunity we have today, which we are very grateful for, is really to talk about our experience in Queensland. Both Stephanie Gallagher and Dr Mark Waters will speak, really, from the perspective of those who are actually sitting making decisions about registered medical practitioners in Queensland. Matthew and I are AHPRA staff and we are coming from the operators of the system perspective in Queensland. I might just add that all four of us have our formal involvement in Queensland in our capacities at the moment is all since May this year, so it is quite a substantial degree of expertise and experience in the systems of health care and regulation in health care. However, our involvement has been post some recent events, so our perspective is somewhat related to the changes that have happened in Queensland recently.

One of the things that I would quite like to be able to illustrate to the committee is some of the changes that have actually happened in Queensland within the current legislative model because I think—one of the things I have heard today, and listening to some others giving evidence, is there are substantial changes occurring in Queensland with the Health Ombudsman Act and its implementation. There is also quite a degree of, I might say, flexibility that is available within the National Law as it stands both in Victoria and in Queensland, which we might illustrate to you, to actually do many of the things that have already been raised, and perhaps pick up on some of what Dr Forrester and others have raised as concerns with the system. We will pick up on some of those areas.

I think the other opportunity I would like to, offer to the committee, is perhaps, that you may want to consider a request of us, particularly our colleagues in Victoria and the medical board in Victoria, as it is a state-based board in Victoria. The decision makers for medical matters, two of them are here. There are two that are not here as part of the Queensland medical interim notifications group, so it is a state-based system, I would say, and our legal structure in AHPRA is that we are a statutory authority in each state and territory, there is no federal legislation that is involved in our operation, our accountability is to state ministers only, and parliaments through those ministers. We do not have an accountability elsewhere, I should say.

I think the opportunity, perhaps, then, in terms of for Victoria and what you might consider recommending to Victoria is really to help explain how the system is working in Victoria and how some of the concerns that have been raised in Queensland do or do not manifest in Victoria, and one of the other things that I guess I would like to point out is that, based on our experience, I think there are some demonstrable points where Queensland actually is different. Several of those are, perhaps, as follows. One of them is that Queensland had at least 30 per cent more open complaints that were transitioned from the legacy boards in 2010 into the national scheme for the Queensland Medical Board and other professions to deal with. That is a marked difference than Victoria, for example.

We started in Queensland with the legacy of greater numbers of notifications, greater numbers of open notifications, and, quite frankly, as Dr Forrester's inquiries have pointed out, some matters that were open for substantial periods of years prior to the national scheme arriving, so I think, at times, it has been somewhat difficult for us to respond to matters that have been open for five years before we actually existed, notwithstanding the fact that many people did have expertise in the prior system and prior boards before transition into the new scheme, so I think that is one of the particular challenges of change in the transition that is occurred. We continue to have the highest number of notifications other than New South Wales. For example, our annual report will show, that has just been tabled in parliaments around the country, is that for the last financial year, 12-13, Queensland had recorded 2,042 notifications during that period for all registered health practitioners and, in Victoria, obviously with a larger population base and a larger number of registered health practitioners, the number of notifications that was received was 1,844. You can see the difference in, again, the higher number of notifications that are occurring in Queensland.

There are many books, that refer to why that might be the case, I am not going to try and give you clear answers as to why there are notifications that have come in at a higher rate in Queensland other than to, offer that it is also true for mandatory reporting, so the requirements that are universal now really are very consistent across the country for mandatory reporting. We have a higher rate of those in Queensland and we also have a higher rate of taking immediate action where that is required based on the risk to the public.

The one thing I would say, perhaps it is an extreme example, but it is nonetheless one that is often used, is the case of Dr Patel and recently—yesterday, in fact, the Medical Board of Australia released some advice to update the public on where we are up to. That has been a matter, as many would be aware, whereby there have been criminal proceedings that have effectively concluded in the last day. Our ability, the board's ability to actually then progress with those notifications that have been open since 2006, has been incredibly limited, so we have had those matters filed in the tribunal.

Have we been able to deal with the performance of that particular practitioner who is no longer registered? We have not been. And we are now able to recommence our proceedings, now that the criminal matters are over, but I guess I use that extreme example, and it is an extreme example, just to explain that there are often reasons why a matter has not actually progressed, and it may seem an incredibly ridiculous number of years that may have taken, many people may agree that is the case; however, we have not been able to act on those based on the criminal proceedings that have occurred. Now, that is not the case for every registrant, obviously, but it is one of the features of the system.

I guess what I would say to you, again, is I think there is really a need for us to consider what are the similarities and I guess for you to consider what are the similarities in Victoria and what are the differences in performance. We have some substantial changes that have occurred in Queensland, really, as a result of recent events, and a consideration by the minister about the change to the model in Queensland. Within that, we now have an interim group, which Stephanie and Mark can talk to you much more about and answer your questions around a fifty-fifty split of practitioners to non-practitioner members who are considering matters relating to complaints about doctors in Queensland. Stephanie is not a registered medical practitioner, clearly, and she is the chair of that group. That is quite possible to achieve within the current legislative model that we have. We are still operating under the National Law unamended, it is no different in Queensland at this point in time, and that is a model where I know the minister and Dr Cleary, who was giving evidence here earlier today from the department, have flagged that they see that they have some confidence that matters are being dealt with in an appropriate way by this group. I think that is an example of some of the changes that have occurred within the model that we have at the moment.

I will not try and go into the performance numbers at the moment, but we do have a substantial, improvement, I would say, in the number of open matters that we have in Queensland now as compared to some months ago, really, from the start of this calendar year, particularly would be the area that I am looking at. I think there is demonstrable improvement that can occur within the current arrangements and there is a way of doing that within the current scheme. I might finish there and allow you—

The CHAIR—I will ask other members of your other panel to comment as well, but just a couple of points that you raised, obviously if there was any civil proceedings and they occurred on quite a regular basis in relation to—especially in obstetrics and you have mentioned the extreme case of the Patel case, the criminal proceedings, that they are not significant numbers we are talking about, are we? In terms of those complaints in Queensland, the 2,042—

Mr O'BRIEN—There is a reason for the delay, yes.

The CHAIR—The reasons for delay. I mean—

Mr ROBERTSON—I think there is a range of reasons and, you know, I am not trying to give you an audit of all of those matters, but I think one of the things that is in place now, and it would be something that perhaps others here might want to illustrate further, is really to address the issue that Dr Forrester raised in part. There is a system in place that allows for ongoing risk assessment of open complaints, for example, open notifications in Queensland.

We are always able to take, under the current model, immediate action, so it is up to QMING in this case to consider and AHPRA to advise them whether we believe there is a risk to the public sufficient to meet the requirements for taking immediate action, and that would be regardless of whether there are criminal or other matters that are on-foot, so there is an ability to protect the public based on the risk that is perceived to them at any point in time. I guess what I am illustrating is the fact that we cannot conclude some of the matters—

The CHAIR—I think we understand that because of those issues, I mean we are very aware of that and we completely agree that is the right and proper process to undertake.

Mrs PEULICH—Sorry, just on the risk and audits. You say that you had a system for undertaking risk reassessment on a regular basis, but was there an audit of those decisions that was integral to the process, and, if so, why was it not reflected in the files.

Mr ROBERTSON—There have been several, and some of them have occurred post Dr Forrester and Chesterman's work.

Mrs PEULICH—By why did not it occur before?

The CHAIR—I know, but there has got to be a reason. You say they have been demonstrable and prudent, and I accept that, but why did it have to happen post the reforms, why did not it happen before? What was it about the model that did not drive those improvements?

Mr ROBERTSON—I think it would be difficult for me to comment on the operations of Queensland prior to me being there, so I will not try to do that. From a national perspective, I would say that I think there are some challenges with implementing the level of change that has occurred, and I think there are frankly reasonably well documented and they have been the subject of submissions both to your inquiry and to others.

Mr O'BRIEN—Which ones do you agree with? We would like to start with understanding the problem and then look at how systemic it is and how much—

Mr ROBERTSON—Yes.

Mr O'BRIEN—I have not heard too much yet, and no disrespect to you, of acknowledgment of the problem. If we do not understand the problem, it makes it hard to deal or acknowledge the problem, deal with which are the best solutions.

Mr ROBERTSON—I think I would sit here and say, AHPRA has acknowledged it has a problem, I think I have said to you Matthew and I are in Queensland from AHPRA, we were not here prior to May and we have been within AHPRA. Matthew has come from our Tasmanian office and has been running that, and I have a national role as well as Queensland accountability, so we have recognised in response to concerns that have been raised through these processes that we need to have some changes to some of our systems and processes, and we are putting those in place.

As you would appreciate, there has been a range of maturity that is been occurring across the national system and all of our state offices during the life of AHPRA, and I think some of the—there are quite a number, actually, of the matters that Dr Forrester reviewed, as she mentioned, were actually in that first year and a half, two years of the scheme. Now, I am not sitting here suggesting that there should not be performance improvements, I absolutely agree there should be, and there are. What I am saying is: I think that some of that is a period of maturity that is been occurring with us putting systems and processes in place to do that.

Mrs PEULICH—I accept that, if I may, but every organisation has to have a capacity to identify the reasons why its performance is—and where it is problematic and how to improve. Coming down to unpacking the reason, I accept the fact that you are only a newcomer to AHPRA, many of us have gone into organisations or businesses where there is obviously history and you cannot tell me that you cannot look at the operation, the people, the process and the structures are not, to use your expertise, to gain some insight as to why the problems occurred and why this improvement was not able to occur within the organisation without that external pressure.

The CHAIR—Can I just follow on from that. Is it a response to the Health Ombudsman bill that you have got this input that you have into Queensland and dealing with the department and the legislation?

Mrs PEULICH—Was it people, processes or structures, or all of the above?

Mr ROBERTSON—I would say that it is a combination of factors, and I guess what I tried to illustrate before to you is that I think there are some different demographics in Queensland in terms of the nature of complaints, and there is a different—so to go back to the state based complaints system, I would argue there is a state based complaint system now, and there is in Victoria, in my understanding of what that means to be a state based complaint system, so there is a national organisation called AHPRA and there is a national entity, the Medical Board of Australia.

All of the decision making about registered medical practitioners, all of those decisions about individual registrants, both registration and complaints handling or notifications in our context, are made not by the national board, they are all delegated decisions delegated to the state board. Prior to Stephanie and Mark and the Queensland Medical Interim Notifications Group being in place, the Medical Board of Queensland and its committees had that role, they were delegated those functions, so I guess that is why I am referring to a state based approach to regulation. It is not quite answering your question, but just to explain the context of the state based model, that is the model.

The systems and processes, then, that were being used were really going from saying we have a long history, in fact, and over 100 years of medical regulation in Tasmania and other places, which is you know, quite frankly a hard thing to change, how it will work overnight. On 1 July 2010, for most of us, other than Western Australia, the change from one system to the next was quite a substantial change. I am not suggesting these are excuses, I am just suggesting that you are asking me a question about why some of these things occurred.

I would say to you my experience is that is quite a big change and quite a difficult thing to do, and that the change from having, for example, different definitions of practice, different standards of practice, different requirements for English language and so on from prior to 1 July, they are all changing to a common standard nationally on 1 July 2010, and then actually having a system to actually respond to those so that all the complaints that relate to those standards are then addressed in the same way, is quite a mammoth task. I think we are a long way down that pathway and I guess one of the concerns I would have is about how we manage in Queensland to deal with another change to the system, and I think, you know, I would sit here and say,

'AHPRA's very committed to making the Queensland model work and the implementation of the Health Ombudsman, and we do work closely with the department, with the HQCC and others.

However, I guess one of our goals at the moment would be to make sure that we do not have the challenges that have come up based on the last transition from one model to the next, and acknowledging that was a national change, I think a state based change has the potential to be quite difficult as well.

The CHAIR—Thank you very much, Mr Robertson. I think before we go onto the next question we might just hear briefly from other members if they would like to make a comment. Would you like to add anything further? You do not have to.

Ms GALLAGHER—I am happy to. I would like to pick up a couple of things Chris said, firstly. In terms of the quality assessments and undertaking reviews and things, I think it is fair to say that at or about the same time that Kim was doing her work I had actually been engaged to do a review of all investigations in this state across all boards that were more than 12 months old, so there was some quality process in place as well in terms of assessment.

Mrs PEULICH—Before you?

Ms GALLAGHER—I do not think before me, but that was about the time with Kim as well, so that was going on. I think one other point I would like to make is—

Mrs PEULICH—But it was not systemically built into the model.

Ms GALLAGHER—I think it was in terms of there were determinates about how long investigations should ordinarily take. These were recognised as being outliners for the use of the term, and as a result of that, those outlined were to be reviewed with a view to determining whether or not, as you suggested, within the system or procedures what was causing these matters to become delayed. I think it was very interesting, in fact, because I think over across all of the professions that were caught at that time by AHPRA there was about 91 matters. About 60 of those were medical board, but what was particular interesting was that more than half of them, just over half of them, were about the same nine or 10 practitioners, so what had been happening was more systemic.

The CHAIR—A process.

Ms GALLAGHER—It was a process issue as well, because if you have got one investigator who has been doing something for 12 months, having looked at 14 operations done by one practitioner, and then suddenly you get another complaint in about the same practitioner with another three patients, logically, they had to put the two together. What happened was nobody got to finish an investigation because the complaints were coming in the door about the same fellow, about different surgeries or the same woman, about different procedures, so there were some sort of systems issues that have caused that sort of problem. That was just once but, really, it is just a small point I just wanted to make.

The other thing that I think was inherent within what Chris said, but I think should be said explicitly, is that the changeover you had from the old to the new national scheme was not a changeover like we are going to see from one entity to the Health Ombudsman. It was actually the bringing together of 14 boards, all whom have their fiefdoms, all whom have their own chiefs, all of them have their own methodologies. I think that amalgamation was a very unhappy marriage and a difficult thing to manage. I think that growth period and the maturity period of some two years or so, about the time Kim comes on board to do her work, I mean, you would be very hard pushed actually to look at what had to be achieved across that period. I mean, I am not AHPRA, obviously—

Mrs PEULICH—Was the implementation botched?

Ms GALLAGHER—Well, I think it was just—I do not actually believe, looking back it now, coming in and looking at these investigations and having, once upon a time, chaired nursing standards, that committee, and looking at it now I do not think they realised what a big job it was.

Mrs PEULICH—That is what I mean, was the implementation botched?

The CHAIR—And we know all the issues in relation to the registration process, which has been, you know, they have generally been resolved, so that is fine, and that is part of that very large implementation process, but I think that getting back to the point that we need to be looking at in relation to here is about the protection of the public and the safety component surrounding AHPRA and their role, and, you know, have we got the systems and robust systems, so I might just ask Ms Mikakos if—

Ms MIKAKOS—Yes, I have got lots of questions. Firstly, just following on from that point, Ms Gallagher, about those practitioners who had a whole series of complaints, what changes have been put in place to, you know, address these cases earlier on without having a dozen cases? If there are two or three, then surely the alarm bells should be ringing.

Ms GALLAGHER—Yes, I think there are different things. I mean, we were lucky, if you like, when QMING came on board following Kim's report being published, to be given a fairly—a fair length of rope, if you like, to go about implementing change that we thought would accord with what had been suggested and what would afford better protection of the public, so we were able to, firstly, look at issues of delay. The first thing, frankly, we did do was undertake an audit again of all the matters in the investigation stage with a view to the committee with the determining power and the responsibility to protect the public to go about reassessing risk across all of those matters and determining if there was any change in perception or public risk as a result of these being outstanding because, of course, sometimes investigations are not going to take six months or three months, they are just going to take longer because there are 62 patient complaints, or whatever the answer might be.

But I think to look at just how long is this taking is not the question, as you have said, it is a question of protection of the public. If you have put in place the mechanism that afford protection of the public, then you have achieved your outcome. If you have got appropriate conditions in place or you have got an appropriate suspension in terms of whatever it might be, you can serve that master. Primarily, of course, the protection of public, but you can achieve some accommodation that works as best you are supposed to for everybody, because the obligation, of course, in our seat, is to protect the public but adopting the least restrictive mechanism we can in terms of practitioner's practice, so you can serve both of those things.

But there has also been other action that has been taken. I mean, there have been a series of KPIs put in, in terms of when determinations, time frames, the determinations and decision-making, and review, and those sorts of things, frankly they are much the same, they are not identical to what they are going to get for Health Ombudsman and, frankly, you could do that without a Health Ombudsman, you could change around legislation and do it as well because its state legislation, and superimpose it upon the national scheme that there are things like now, categories of assessment so that we have high risk assessment matters and we have normal risk assessment matters, and the high risk assessment matters come to us within seven days for assessment so that we see those immediately. In fact, as a process, they do not go firstly to the practitioners for response; they come straight for an action as a high risk matter so that they are seen—because they are perceived as being high risk by people who are a special high risk team, if you like. They come straight to us and the normal matters proceed in the ordinary way going through assessment with an opportunity to respond.

Ms MIKAKOS—Just following on from what you have just said, with those KPIs, are they comparable to what the Health Ombudsman will have? 12 months is the key timeline or—

Ms GALLAGHER—Yes, they are comparable, certainly in terms of the risk ones, the ones where you are really looking at the public risk, like high risk matters, yes, they are they same, essentially the same.

Mrs PEULICH—Any differences?

Ms GALLAGHER—I do not think so. I would have to—to be honest, I would have to go check and measure exactly. My recollection of having looked at the legislation means they are essentially the same as what they were.

Mrs PEULICH—Okay, thank you.

Ms MIKAKOS—I have a number of questions around your views around the new system here in Queensland. I do not know if we perhaps want to address other issues first and then come back to that, because I guess—

The CHAIR—I think you were just touching on it, so do you want to go first?

Ms MIKAKOS—Okay, all right. Well, I am obviously interested in your views about the new Health Ombudsman system and whether you think that represents some significant improvement to how things will be done here in Queensland, but I particularly want to come to the issue of resources because as I understand the new Health Ombudsman system is going to be funded by the Queensland practitioner's fees being transferred to this new body, how is that going to impact on AHPRA's functioning if you lose all the resources and, you know, if other state governments, for example, might be considering going down the same path, are we going to end up having the national body fall over. I do not know if you are able to comment on the issue of resources at this stage.

Mr ROBERTSON—I think maybe if I could pick up the two aspects of your question, I think the first one is we really do not know because we do not know who the Health Ombudsman is. I think we heard this morning that we do not know what the KPIs are for the ombudsman. We know that there are some legislative time frames, which is what I think what Stephanie was referring to, and they do link to our administrative KPIs. I think that we need to wait and see who the ombudsman is in terms of an appointment being made which is iminent, and then my understanding from the department and the implementation team is that there is quite a degree of discretion, and I think we heard that reflected this morning in evidence to you around how the ombudsman will do the ombudsman's work, and so we are not entirely clear how it is going to work.

That flows into your question about resources because, I mean, the consultation process we engaged in with the department around the development of the Health Ombudsman model was actively considering what the translation of the New South Wales co-regulatory model was to Queensland with some differences. Now, there are some similarities and there are some substantial differences, I think as you are aware and have been discussing. One of the differences is that in New South Wales that was the model that existed prior to the national scheme, that was not a transition, effectively, to a new model, arguably, that has helped maintain their performance.

The other thing that it has as a key feature of it and one of the reasons I would believe that it is been retained is that it is subsidised by the state government, so the operations of the Health Complaints Commission in New South Wales that deal with a small number, and I am not exactly sure of the percentage numbers, but I think it is somewhere in the order of, perhaps, five per cent of notifications or complaints about registered health practitioners will stay with the Health Complaints Commission and the rest will go to our equivalent after its equivalent of councils in New South Wales. The New South Wales Government funds the operations of dealing with that five per cent, not registrants, so there is a different registration fee in New South Wales.

The CHAIR—Similar to our Health Services Commissioner in Victoria, which is paid for by the government.

Mr ROBERTSON—Yes, that is exactly right. Now, in Queensland, there is already existing funding available to the government to what I understand will transition from the Health Quality and Complaints Commission into the Health Ombudsman, so there is roughly, I think, $11 million per annum that is the funds that are provided for that at the moment.

What we are unclear about is what the minister will determine is the amount of funds that will go from registrants fees in the national scheme to fund the operations of the health ombudsman. What the legislation says, as I understand it, is that he will need to have regard to what it would have cost AHPRA and national boards to deal with those matters. I guess the question that is unclear is how many matters will the Health Ombudsman retain, will it be five per cent, like in New South Wales? We clearly can model that, we have an understanding of how that works, but there is a discretion that is involved as to how many matters the

Health Ombudsman refers on to AHPRA and the board, so I guess at this stage it is very difficult to answer the question other than knowing that there are some principles already in operation from New South Wales fees whereby the intention is, and the express intention of ministers to us through a policy direction, is that there should not be cross-subsidisation between professions, so medical practitioners in New South Wales should not be subsidising other practitioners with their fees, and likewise there should not be a cross-subsidisation between states and territories.

The fact that New South Wales has chosen a different model of complaints handling, my understanding from the minister's direction to us is that their intention is not to have, for example, Queensland based registrants paying for the New South Wales model and vice versa. What we have seen over the last three years in New South Wales is that we have gone from all professions having a subsidy, so they have a lower registration fee in New South Wales, in some cases not a lot lower but it is lower. We have now got two or three professions, I will have to check exactly how many, I think it is three who this financial year will actually have a higher fee in New South Wales than the rest of the country because the cost of that model for those professions is higher than the national fee.

The CHAIR—Members might be able to actually clarify for me, but I think we were told there was a $101 million operating cost that AHPRA currently operates on.

Mr ROBERTSON—In the last financial year, that is right.

The CHAIR—I cannot quite recall if that is divided up proportionally between the states, or is that just the national body? Am I right in saying—

Mr ROBERTSON—It is AHPRA's operations in its entirety.

The CHAIR—Correct. There is no digging up with each state, so it goes directly against what you have just said, I think.

Mr ROBERTSON—Okay. Perhaps we need to explain that further then, because there is a budget that Queensland has.

The CHAIR—Out of that $101 million? That is what I am asking.

Mr ROBERTSON—Yes, absolutely.

The CHAIR—Right. That is what I wanted.

Mr O'BRIEN—In fundamental terms, if Queensland is going to move away from the national complaints system in whole or in part, and to some degree one would think that the contribution from AHPRA or the contribution to AHPRA would reduce proportionally because they have to contribute to another body.

Mr ROBERTSON—Yes.

Mr O'BRIEN—It would be basic logic, it may not work out that way, but is that what you would anticipate will happen?

Mr ROBERTSON—If I understand you correctly, yes, I think so. It is a transfer of the cost to where the work is being done, if I could describe it that way as my understanding of the intention. I guess the risk is, and to go back to your question, what would that mean? If the cost structure of the Health Ombudsman is greater than the cost structure of the national scheme, and I do not know whether it will be or it will not be, I think that is yet to be determined, but if it is, and to the degree potentially that it duplicates the existing bodies within the national scheme, then there may be a greater cost.

I guess what I am saying to you is my understanding of the experience in New South Wales is despite the subsidy from the New South Wales government to fund the Health Complaints Commission, some professions costs of running that co-regulatory model are higher than the national registration fee, and that is

only as of this current financial year.

Mr O'BRIEN—I am presuming, I have no idea what is going to happen in Queensland let alone anywhere else, but that is just a logical presumption. Could I go with that? One of the fundamental things we heard at the start of our inquiries was there were 1,200 meetings that occurred between all the various levels of the bureaucracy, and there is still retention of the state systems in part despite the laudable lanes of the national system, and ultimately back to the practitioner level, if you start there, fees for registration have increased but they view the level of service has decreased, and we have specific submissions about that.

At the same time, you have got these problems occurring with the complaints handling as the national system is, you know, whether coming to terms with it or is it a more fundamental problem with having a national complaints system, and that is in a part what we have come up here to consider. If we go to New South Wales, as you say, which is never transferred, do you consider that there are advantages in that system operating? Just leave the transition layout for the moment, we have to put it back in shortly, but are there advantages in having, you know, national boards, registration, accreditation, but a more state based complaint system? As I take it from your submission to us, you would say there are disadvantages. I am interested in what you will say.

Mr ROBERTSON—My answer would be: we will make whatever system that parliament, the jurisdiction has in place, work, would be my statement to you. I do not think I am in a position to say whether New South Wales is a better model than anywhere else, it is a different model. There is some research occurring now into the outcomes across the different systems, so comparing New South Wales with the complaints handling experience or outcomes in other states and territories, and that is some ARC funded research that involves a number of academics and universities in looking at that, so we are keenly interested in the results of that work.

Mr O'BRIEN—It has not resolved yet because—

Mr ROBERTSON—Well, it is really looking over a longitudinal period of several years, which I think you would arguably need to do to draw any meaningful conclusions given the substantial changes to the system. It is my expectation that, to go back to something that I know you considered in your previous hearings, is there is an independent review of the National Registration and Accreditation Scheme that must occur sometime soon.

The CHAIR—I think it is imminent, isn't it?

Mr ROBERTSON—Well, our understanding is that it is imminent and that we would expect a number of the issues that you have raised, a number of the issues that Dr Forrester and others have raised around transparency, for example, for notifiers in the scheme are constraints that are actually within the law that parliament have provided us to operate with. They are not things that we can administratively change, and I think it would be AHPRA's submission, and we have provided some joint submissions with national boards previously to government, to say there are aspects of the national law particularly to do with transparency and keeping notifiers informed that we would like changed.

We are on record as having recommended some of those things. The vehicle that we understand to do that is primarily the review of the national scheme, including some review of the national law, and I think that would provide a very comprehensive and coordinated mechanism, we would hope, to actually address a number of the issues that you are all raising and that we have raised and that others are raising about how the maturity of the law and the areas that we would see as barriers to transparency could be improved.

Mr O'BRIEN—Could I just go to one specific example, and I am happy for your input here as a medical practitioner. One of the concerns that Dr Forrester and others have raised to us in relation to—in a sense, one would say it is a surprising problem in the scheme that she identified—we narrowed down to about 363 complaints amongst others that were not dealt with in a timely manner, and the two factors she brought to our attention in relation to timeliness was they were waiting years for even an initial assessment to be made, and then sometimes for an appointment of an investigator would also take some time, and in many instances these were simple complaints.

I think the upshot was including some internal recommendations that are occurring now was the introduction of the triage system, and the irony about that is, with my limited knowledge of medical matters, triage is an essential medical term that happens when one goes to a hospital and you go to the triage nurse to see how these complaints—so I find it a bit surprising that the establishment of the national body would not have thought to—and I know you were not there and I am trying not to be—

Mr ROBERTSON—Shall I just clarify it? What I was saying before about my involvement with the scheme, I have been involved with the scheme since its outset, I have not been responsible in Queensland.

The CHAIR—In Queensland.

Mr ROBERTSON—My understanding is you are inquiring about Queensland's operation.

The CHAIR—Yes.

Mr O'BRIEN—We are.

Mr ROBERTSON—I am saying to you it would be difficult for me to comment on operations in Queensland prior to me being here, and that was from May this year.

The CHAIR—But you have been involved with AHPRA from—

Mr ROBERTSON—Absolutely, yes.

Mr O'BRIEN—The end of the point. With the levels of governance, if you like, right up to the UN, there are great laudable aims with having a UN, but if it is got a criticism it is regarded as too bureaucratic and not nimble enough to deal with decisions. In looking at this in short compass, whilst it might be good to set national standards, national accreditation, there may be advantages particularly when one is looking at resource allocation and the implications from losing a doctor from, say, a regional hospital, for having a state based complaint system even within a national accreditation. I know there are transitional issues each way, but I would like to first of all get your explanation as best you understand it as to how APHRA would have been informed without a proper triage system, like, how did that happen, and, secondly, which of the two options in a sense we consider in the Queensland analysis is the preferable system to adopt.

Mr ROBERTSON—I might start and then ask—

Mr O'BRIEN—Yes, sure.

Mr ROBERTSON—I will ask the others to comment. I would suggest that AHPRA did not start business without a triage system. I think the application of that triage system is difficult.

Mr O'BRIEN—Without a good triage system?

Mr ROBERTSON—Well, no, I suppose that is not my point. My point is—and perhaps it does go back to your comment—

The CHAIR—Sorry, what was the comment? Which comment? The multi-headed Hydra?

Mr ROBERTSON—I guess again just to look at the sheer change that has occurred, you have got for all of the jurisdictions in this country, you have had sovereign boards—just take medicine—sovereign boards in every state and territory who suddenly go from that to having—and in some cases, for example in South Australia, literally the legislation was passed on 30 June 2010. It was not certain that the following day it would be the national system. Again, it is not an excuse. I am just illustrating the facts. That is what occurred. That means that people need to have a reasonable degree, I would suggest to you, of contingency in place about the fact that it may not happen and that they may need to continue doing things the way they have always done them. Frankly, after it changed they may have continued things the way they used to do them as

well.

So a state based system is what Queensland had up until 1 July. I would say that there are largely very strong resemblances of a state based system in Queensland still in the decision-making about—medical notifications happen in Queensland. It does not happen in Melbourne and it does not happen anywhere else. The decision-makers are the people in Queensland, the AHPRA staff are the people in Queensland. They are operating national systems. To go back to your point around the triage system, I think those systems were poor initially, in my view, and have improved. I think that is one of the changes that we have seen and I would, as I said before, relate that to a maturity and going from one range of systems to one system overnight. Clearly, preparation needs to occur for all of these things. Again I am not suggesting that is—

Mrs PEULICH—When you say a maturity, is that code for governance and practice?

Mr ROBERTSON—I think it is—

Mrs PEULICH—I mean, obviously having your position nationally you seem perhaps unable or unwilling, or maybe there is a conflict of interest there for you, to actually elucidate the issues. I cannot believe that you are involved with a national body that you cannot shed some light as to where these issues are, why the regular reviews of risks have not taken place, why a slightly more independent audit did not take place, why the triage has not been effective, why the KPIs were not there. I cannot believe that you have been involved with this organisation all the way through—and we are not just looking at Queensland; we are looking, obviously, at how AHPRA works in relation to vis-a-vis Victoria—that you cannot shed some light as to where the problems are and why.

Mr ROBERTSON—I would suggest to you that I have and I am happy to explain further if you would like but I certainly would not want to give you information that would mislead you in any way. I am telling you what I believe to be true and what I have witnessed. My role in the national scheme is the director of policy for national boards. I have not had a role in managing notifications. I apologise if it appears that I am avoiding the question. That is not my intention at all.

The CHAIR—Maybe when we get AHPRA back into Victoria we can ask that question.

Mrs PEULICH—Yes.

The CHAIR—I think that is something—

Mr ROBERTSON—I have not had direct accountability for the systems and processes about how notifications work but that is something clearly that—

Mr O'BRIEN—I am happy for your answers. I just wanted, from a practitioner point of view, Mark, Dr Waters, and I know—sorry, Amanda, but have you got any further insights as to where the governance needs to take place on the complaints management or how it is best administered?

Dr WATERS—I think it is best administered—this is going to be a circular answer but I think it is best administered where it would be most effectively administered. I think it should be a slightly—and I think there is a slight misconception, and again before May I knew—I have been paying my fees every year. Do not misunderstand me. I had an interest in registration but I kind of just—they sent the thing and I sent the money back.

The CHAIR—You pay it.

Dr WATERS—No-one rang me up, so I thought it was okay.

The CHAIR—That was a good sign.

Dr WATERS—Until someone rang me up and said, 'Will you be on this board?'

Mrs PEULICH—The file may have been in the out-tray.

Dr WATERS—Yes.

The CHAIR—So you have just come onto the board recently as well.

Dr WATERS—Yes, for what was going to be quiet a short period of time, but anyway it is been a bit longer than that. My response to you is this. I think that in fact the complaints management is local here and I suspect is local in Victoria. Currently it is local. It is all run locally. I guess—and this is going to sound like a criticism but I do not think that there was a big change in processes when it changed from the old board to the new group in 2010. I think the system that we looked at when we came in was perfectly designed to get the outcomes that they got, and I think your questions about the Health Ombudsman are interesting because they are structural but they will be only answered if the systems that are put in are designed to get the outcomes that you want. I know that sounds obvious but I used to run hospitals all my life, until recently, and that is really a common thing to happen, which is that you design a system for the outcome you want rather than—

The CHAIR—Aren't they putting that in place because you have failed?

Dr WATERS—Well, I am not quite sure that I have failed but—

The CHAIR—Or AHRPA have failed. Not you personally but AHRPA have failed.

Dr WATERS—But in general terms I have failed many things in life and that is absolutely one of them.

The CHAIR—If I have offended, I am sorry.

Dr WATERS—No, that is all right.

The CHAIR—That is the point though, isn't it? I mean, the reason this bill is before the Queensland parliament is because they have felt that the system has failed them.

Dr WATERS—Well, I cannot speak to why the bill was put before parliament but, as a practitioner, my view was that that the functioning of the medical board was unsatisfactory primarily around the length of time it took to resolve matters. I had been—

The CHAIR—A medical board, not AHPRA?

Dr WATERS—Yes. It is interesting. Well, the accountability, so I am talking about now my views about the process prior to joining.

Mr O'BRIEN—Yes, that is useful.

Dr WATERS—When I was running hospitals and when I was practitioner—well, I still am a practitioner, at the moment anyway. I have to be careful what I say. But as a medical practitioner and as a manager of hospitals I was always surprised at how long things took. I think now that I am working within the fold, if you like, working with QMING or the medical board and AHPRA, I think that some of those delays, frankly, were unnecessary and some of them are necessary. I think you will find as you dig more deeply into this that this becomes quite a complex environment in which to work.

Certainly my understanding of the previous system is that it was set up with various subcommittees and they met at various times and there were subcommittees referring to boards and all sorts of things and there were delays involved with that, whereas under the current system we meet every week rather than every fortnight or every month and there are no subcommittees. It was not common when we started but it is common now for us to get certainly all the high-risk notifications—I mean, you can see the dates of the notifications—within about five days of anyone notifying anyone. We commonly now, commonly, every week—almost every week—we would be making decisions on high-risk matters within five days of them being notified which is,

in my experience anyway, a slightly different environment to the way it was before.

I would say to you that if you want a different outcome in Victoria, then I think, one, you should focus on the processes that you put in place. Now, that may or may not be the same as a new structure or a new organisation. What the new organisation does will be dependent on what the new organisation does. Do you get my point? If the new organisation puts in place processes which have inherent delays or circular conversations, then you will get an outcome which reflects that.

In terms of the actual decision-making, I have found it to be quite a more complex environment than I had thought it would be. I noted Dr Forrester's comments around consistency in decision-making. It was something when I joined that I think we were all very keen on having. I think it does fairly easily fit in terms of why this is so. When I look at the complaints and notifications there are two categories. Well, there are a few categories that are really quite easy, that are less complex. They are certainly difficult decisions but they are not complex. The issues of sexual boundaries really relate to matters of fact, so they are quite easy.

The CHAIR—We have had quite a lot of evidence in relation to different complaints processes and—

Dr WATERS—I guess I would say that the reasons there are apparent inconsistencies is that I think it is almost inherent in the nature of the notification.

The CHAIR—I understand that and I think what we are trying to understand is if there is a notification and the health service has not been notified, then potentially a patient is at risk, but I will not get bogged down on that because unfortunately we are running out of time and I know Mrs Millar has a question or two.

Ms MILLAR—I have a question and it is forward focused rather than looking at the past events, so you have stated to us today that you are very committed or AHPRA Queensland is very committed with working with the new ombudsman when appointed under the framework of a new bill.

Are there any aspects of the new bill that would pose any concern to you in terms of being able to meet the expectations that we have been talking about today with regards to protection of the public and timeliness of investigations? Is there anything in the new bill that concerns AHPRA?

Mr ROBERTSON—I think we have worked hard to ensure that we would have conveyed those to Queensland and through to Michael and the minister prior to the bill being finalised, so I would say that I think they are small, but some do exist. I might ask Matthew to expand a little. I think we have covered the aspect of the financial—like the resource based risk because whilst there is a strong degree of discretion open to the ombudsman to say—for example they may take 25 per cent of matters that come through that are health performance and conduct because they could. We need to have a viable model that delivers the rest of the service and if we do not know what the rest of the service is I think that is quite problematic financially in resource based, so I think we have covered that.

Ms MILLAR—Yes.

Mr ROBERTSON—There are some other specific risks that Matthew might want to explain.

Mr HARDY—I think—sorry.

The CHAIR—No, please continue, Mr Hardy, I am just trying to work out our time frames and if you could—

Mr HARDY—I will be very brief.

The CHAIR—I am sorry to put the pressure on you.

Mr HARDY—It is probably not surprising that it will be in the detail, in the implementation. So it is looking at things like migration of data and of any open notifications that we have got in the system now and

making sure that they do not slip between cracks, which could possibly have been a problem with the transition to the national scheme. That complaints being dealt with under old law and new law pose a significant risk; challenges to the new legislative requirements, so at the moment we have a number of matters in tribunals where there are actually challenges to the legislation and the legislative provisions and how that might extrapolate to new provisions that are introduced under the ombudsman scheme will be interesting.

The new case management model that is implemented by the ombudsman will also be I think really important and ensuring that there is good communication between the management system that is in place in AHPRA and the system that the ombudsman eventually adopts, so I would summarise that I think the issues for us will be in the detail of the implementation from the ombudsman.

Ms MILLAR—Good, thank you.

Mrs PEULICH—Just one last question—and thank you, Dr Waters, for attempting to at least answer one of my questions. You have obviously had some issues/problems—and when I say 'you' I am talking about AHPRA—and could I say a little tardy in identifying them and taking actions, so to whom is AHPRA and its functioning actually accountable? To whom is it accountable?

Ms GALLAGHER—Can I just stop you for a second?

Mrs PEULICH—Yes.

Ms GALLAGHER: As QMING on the medical board we are not AHPRA. They are our secretariat that—

Mrs PEULICH—Yes, I understand that.

Ms GALLAGHER—Yes, so the collective 'you', you will get different answers.

Mrs PEULICH—Okay.

Ms GALLAGHER—If you ask Matt or you ask Chris—

Mrs PEULICH—Okay, let's ask Chris.

The CHAIR—We want to know from AHPRA Queensland's perspective who is accountable?

Mrs PEULICH—To whom are you accountable?

Mr ROBERTSON—So AHPRA Queensland office is accountable; Matthew is responsible for all the operations in Queensland, he is accountable to me and I am accountable to our CEO Martin Fletcher and—

The CHAIR—And your CEO is accountable to?

Mr ROBERTSON—To the Agency Management Committee which is our board of governance.

The CHAIR—Yes.

Mr ROBERTSON—It is not titled a board in our legislation. We have—

The CHAIR—To whom are they accountable?

Mr ROBERTSON—We have 14 different boards. They are appointed by a ministerial council as a collective.

The CHAIR—Yes.

Mr ROBERTSON—That is a legal entity that is created by our legislation in each state and territory.

The CHAIR—So there is not a single person who takes responsibility for the functioning?

Mr ROBERTSON—No, it is a collective.

The CHAIR—Therein lies the problem. Thank you very much. On that note could I, on behalf of the committee, thank you, all of you, for being before us this afternoon. It is been really helpful to have your input and we do appreciate the time that you have taken to be with us, so thank you very much indeed.

Mr ROBERTSON—Thank you.

Witnesses withdrew.

Committee adjourned.