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

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Melbourne — 12 December 2012

Members

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

Chair: Mr E. O'Donohue
Deputy Chair: Mr M. Viney

Staff

Secretary: Mr R. Willis

Witnesses

Mr P. Fitzgerald, Executive Director, Strategy and Policy, and

Ms A. Carlton, Manager, Health Practitioner Regulation, Department of Health.

The CHAIR — I declare open the Legal and Social Issues Legislation Committee public hearing. Today's hearing is in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency (AHPRA). I welcome representatives from the Department of Health, Mr Peter Fitzgerald and Ms Anne-Louise Carlton. Thank you both for making yourselves available, particularly at 8 o'clock on a Wednesday night.

All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975, and is further subject to the provisions of the Legislative Council standing orders. All evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website. We have allowed approximately an hour for the hearing. I appreciate that you have prepared a presentation; thank you for that. All members of the committee are present, including the Deputy Chair, Mr Viney. I will hand over to you to make your presentation. Thank you for being here.

Overheads shown.

Mr FITZGERALD — Thank you. I am Peter Fitzgerald. I am the Executive Director of the Strategy and Policy Division, and Anne-Louise Carlton is the Manager of Practitioner Regulation, which is also part of my division. We would like to say that we are here to help, and the minister has encouraged us to provide as much background as is needed. We have confronted the terms of reference, and we are here to give a briefing on the purpose of the inquiry: the background to the establishment of AHPRA. We will go through some of the acronyms and pronunciations. I pronounce it 'AHPRA'; others pronounce it 'APRA'. I just want to re-assert the offer of assistance, with possible areas of investigation.

You will be hearing mostly from Anne-Louise, who is the true subject matter expert. In all the country there are few people who understand the last 10 years of the history and the nuances of the structure of the National Registration and Accreditation scheme, NRAS. I might begin by talking about the first and third items, the purpose of the inquiry and, maybe to a lesser extent, the departmental assistance.

The terms of reference — I have a copy in my hand now; I think it has been passed around — identify four areas of inquiry. They have some explicit words around the performance of AHPRA — and in the terms of inquiry that is spelt out as the Australian Health Practitioner Regulation Agency; the cost-effectiveness of the agency; the regulatory efficacy; and the ability of the national scheme to protect the Victorian public. Those are the elements identified in the terms of inquiry.

A couple of points might be made about this. Firstly, AHPRA is just one part and one element of the national scheme, albeit an important and a central one. It is effectively the administrative arm of the 14 national bodies, and we will go through some of the 14. We are not expecting that you would have in your head verbatim what the 14 are, but they start with doctors and nurses, and you can pick up some of the others by a sort of process of elimination. Most of the statutory powers under the national scheme reside with the national boards rather than with AHPRA. So there is a bit of nuance about who is empowered to do what and how it all fits together.

The performance of AHPRA cannot be evaluated on its own, and I do not think you should read your terms of inquiry as being too narrowly cast about just the administrative arm, but really the administrative arm in the context of the total scheme. There is a requirement to address the performance of the national boards and other structural elements of the scheme, including the ministerial council. Anne-Louise will provide some detail on some of the structural elements. We have some charts in there that look like an organisational chart — very complex — but she will take us through those and outline the nature of the relationships of one to the other.

Secondly, to examine the cost-effectiveness and regulatory efficacy of the national scheme raises a set of questions, such as: against what sort of standard or benchmark are we looking at the performance of AHPRA and the national scheme more generally? There are three possible approaches one might take to this. One is looking at a comparison with the pre-existing Victorian scheme — that is, Victoria when it was operating on its own, before we had a national scheme — and asking: what is the before and after effect, and what is the impact of having single overarching legislation and a single national administrative arm rather than the old dispersed arrangements with many boards, albeit good boards, in Victoria? The second would be to compare it against the template for reform that the Productivity Commission outlined in its 2005 report, which is now seven years old. That report was entitled *Australia's Health Workforce*. The third way might be to give greater

focus to the regulatory regime compared to what other countries have done. You might compare the costs and benefits and other operational components of like jurisdictions, by which we might think of the UK, New Zealand, South Africa and Canada as being similar regimes of law and regulatory arrangements.

The main difficulty with the first approach is obtaining data. It might be pretty common, in fact, to most of these approaches that good data is hard to find in a common format when you are actually dealing with 10 to 14 professional practitioner categories. So while one would expect that annual reports from the previous Victorian boards would be a good starting point, as the department recently discovered when it attempted to compile data on registration renewal fees, the data is not uniformly available or readily accessible, and it can be resource intensive to go back in time. So if I asked, 'I wonder what a nurse might have paid for registration in 1985?', it might take a bit of work to do that. If I asked that for each of the 10, it might take quite a few resources to do it. It does not look like there is a readily accessible database that we can go to that captures all of that. Stuff that we might like theoretically might be a bit hard to do practically.

Turning to the second approach, the committee should note that the Productivity Commission is drawing up terms of reference to revisit its 2005 report, with a new study scheduled to commence in 2013. We are saying the second approach might be that they had a vision and an estimate of what it felt reform might achieve for national registration back in 2005, and that might, therefore, be a nice benchmark. I should just note that the Productivity Commission is going to do that work itself, and that will kick off during an overlapping period of this committee's inquiry. If we are lucky — I say 'we' collectively — the Productivity Commission might kick off with an issues paper that has a whole swag of data backed by the hundreds of people it has behind them. Then again, we might not be so lucky. You might do your report and they might say, 'Oh, this is good'. Sorry, I am being flippant.

The third approach potentially offers the most value. For example, the United Kingdom's Professional Standards Authority for Health and Social Care recently published a performance review report on all nine of its health profession regulators, as well as a review of the cost effectiveness and efficiency of the health professional regulators, so a piece of work has been done in the UK based on their own regulatory assessment of how they are going.

However, there are complexities. The UK report notes that there is no established model for assessing the cost effectiveness and efficacy of health professional regulators, and that this is the first time such an analysis has been attempted. The good news for this committee is that you will not be the first parliamentary or other committee to do this, but you might be the second. So the committee may wish to draw on all three approaches to see what insights it might get by looking at a bit of each.

Whatever approach the committee does take, assistance from AHPRA would be valuable in securing the data on the operation of the scheme. We have been in contact with AHPRA to say that a review of this nature should be a positive thing for them. There are many things about the scheme that are undoubtedly positive and beneficial, and we should bring those to the fore. There are a number of areas in which there are issues that need to be addressed and it might be an appropriate time to do it.

In that context the committee should note that under the COAG intergovernmental agreement that underpins the national scheme a review is required to be undertaken after three years of operation. The operation began on 1 July 2010. A review needs to occur after three years of operation. The Australian Health Workforce Ministerial Council is presently drawing up terms of reference, and there is just a question about whether it will begin in the second half of the year or whether it begins in the middle of the year or a bit earlier. They are also looking at Productivity Commission timing for the same task.

In terms of the scope of the inquiry, we have taken some themes from *Hansard* which include points recently raised by the Minister for Health during discussion of the motion. We think they give some indicators of the concerns about how the scheme is operating. We have combined these with another speech at the combined national boards conference in September.

I will just go through the sorts of matters and the language used in relation to the national scheme. The need to protect the public is the foremost reason for professional regulation. The cost of the scheme to the community is a matter of concern or the hydra-headed monster which is the national scheme, comprised as it is of many boards and accreditation agencies. I think AHPRA reported last year that there were 1200 meetings of the

various parts of the scheme. So it is both hydra-headed and active, and that carries with it a cost. Then there are the advantages and disadvantages, costs and benefits of the national arrangements, as distinct from more local arrangements. I know the Tasmanians are saying they had more responsiveness in the past. You can see that if you combine with others, you might have more resources but it might be less responsive locally.

We then have improvements that might be made and the role of the standards and guidelines of registration authorities. Then there are difficulties for students, including language requirements, which has been an issue for Chinese practitioners. There is the role of professional recognition of more advanced skills. There is the role of consumers and whether their views are properly represented. There are the competition policy aspects, and Anne-Louise will give us some of the history of why the Productivity Commission was interested in it, and that goes back to the days in which competition policy was up there with the important new national policies.

We have already mentioned bureaucracy. Doctors and nurses health programs are something that you will need to get your head around if you are not already familiar with them. In the past the Nurses Board and the Medical Practitioners Board in Victoria took funds and allocated them to health programs for doctors and nurses who either have mental health problems or substance abuse issues and there is a need to supervise their activities, get them treatment and protect the public. Victoria was ahead of other states in approaching some of these issues in the way that it did. At a national level there is not the same impetus for continuing those programs on an unchanged basis, and it is a key issue for the nursing and medical professions as to how that will occur going forward. The issue is: there is a Victorian history and now there is a national arrangement — how do we get the benefits of both past learnings and future streamlining?

I will refer to some of the points the Minister raised in his speech to the combined national boards conference. He raised issues such as the need to revisit whether we need 10 separate accreditation entities and duplication of administrative functions. He also raised the issue of the need to strengthen the community perspective in all regulatory decision-making. The boards all now have community representatives on them and the Health Minister at least is asking the question as to whether the community representation is adequate and operating well. He also raised the need to search for leaner and more efficient ways of doing business. So far in the creation of national registration there has not been a great demonstration of economies of scale in terms of cost structure. That might occur now. But it is fair to ask why that did not happen earlier and what the expectations are going forward.

The final issue is the need to actively pursue prosecutions in order to protect the public and whether we have the right regime to take the right prosecutions. An extract from this speech been included in the resource material prepared by the department, which we are handing over to you in these two folders.

The CHAIR — Thank you.

Mr FITZGERALD — With that I will ask Anne-Louise to take us through what appears to be a lot of slides, but we are hoping we can deal with them quickly.

The CHAIR — Thank you.

Ms CARLTON — What I was proposing to cover quite quickly is some terminology; a brief overview of statutory registration schemes and what they are and what they do; a little bit about the context of the reform; some international trends in regulation; and the immediate impetus for the reform that led to the establishment of a national scheme, which includes, as Peter mentioned, the Productivity Commission report of 2005 and COAG's response to it.

I want to talk a little bit about the implementation process and then how NRAS works in terms of the legislative mechanism, the governance structure and the scope of the regime and then maybe make a few comments, if I have time, about the national law and how it differs from the previous Victorian arrangements under the Victorian Health Professions Registration Act. Then I will briefly touch on some of the issues that have come up with the implementation of the scheme, and then I will just run through the resource material we have prepared for you.

In terms of terminology there are a lot of acronyms in this scheme. There is the National Law, the principal Act of which was passed in Queensland, and adopting law was passed in Victoria and in every other state and

territory. When we talk about the National Law we are actually talking about all of the laws that have been passed and that apply in each state and territory. They together make up the National Law.

AHPRA, as Peter mentioned, is the national agency. I pronounce it this way to distinguish it from the Australian Prudential Regulatory Authority, which is APRA. There is the agency management committee which manages the administrative arm of the scheme. There is a National Registration and Accreditation Scheme which we often refer to as the national scheme. We have the AHWMC, which is constituted under the National Law with statutory responsibilities. That is the Ministerial Council, which is a regular meeting of all Health Ministers. That is the group that decides on changes to the legislative regime. It also has certain statutory functions which I will go into a little later.

We also talk about the Intergovernmental Agreement — the COAG agreement — which is the agreement that underpins the national scheme and sets the parameters of the national scheme. We have the 14 National Boards; there is one for each regulated health profession and for, in some cases, groups of professions. In the dental area there are a number of different subprofessions that are regulated under that board, as is the case for medical radiation practitioners. Nurses and midwives are counted as one single profession under the national scheme.

We also talk about the accreditation function. These functions are defined under the National Law. They are basically about assessing a program of study to determine whether it meets acceptable standards, so that if someone graduates from that program, they are automatically eligible for registration without having to sit an exam. It is a cost-effective way of assessing whether people are qualified for registration to assess the courses rather than having to examine each individual.

We also have 'health complaints entities' defined under the national scheme. In each state and territory they are the equivalent of our Health Services Commissioner. They have an interface with the national scheme, which I will go into a little bit later.

We also have 'responsible tribunals' under the national scheme. The responsible tribunal in Victoria is VCAT. It has a role in the national scheme. We also talk about 'endorsements'. When you see the word 'endorsement' it is an endorsement of a practitioner's registration, which gives them certain authorities to practice. We have 'notifications' which are essentially complaints, but the term is a bit broader than a complaint because it allows for self-referral or a referral by employers. We have 'mandatory notifications' and powers for the boards to take 'immediate action'. They are some of the terms you will come across as you go through this process.

Statutory registration schemes are pretty similar across many Anglo-American countries. There are statutory boards established with powers set out in legislation. The purpose of the legislation is to generally protect the public. Prior to the 1990s there was no mention of what the purpose of the regime was, but in the 1990s we started to see clarity on the face of the legislation that it was to protect the public rather than to protect the interests of the profession that was subject to regulation. In 2005 we saw a shift to broader purposes besides just the protection of the public. Statutes started to refer to the importance of access to services for consumers. In 2010 we saw a shift again, where the National Law actually has a whole series of objectives besides just the protection of the public. The National Law requires boards to weigh up a number of different objectives when they are making decisions.

What a registration regime does is create enforceable barriers for entry to a profession. It controls the training and practice standards in the profession. It establishes a minimum quality assurance foundation on which the health system relies. If every employer had to make their own assessment of an individual they were wishing to employ in a particular role, it would be a very expensive exercise. The registration regime provides that essential quality assurance foundation on which the health system relies.

The key functions of registration boards are pretty common across jurisdictions. Boards determine entry-level qualifications and fitness-for-practice requirements for registration. They maintain a publicly accessible register of qualified practitioners. They, as I mentioned, accredit or assess approved entry-level training programs and sometimes programs for specialties as well. They assess overseas-trained practitioners for equivalence in relation to their training and qualifications. They set and monitor practice standards, and they receive and investigate complaints in relation to a practitioner's conduct, their performance or if there are concerns about their health. They conduct and/or prosecute matters before disciplinary panels. In some cases they run panels internally; in other cases they prosecute cases before an external disciplinary tribunal. They also monitor

underperforming, unethical or impaired practitioners who have conditions attached to their registration, and they also have a role in initiating prosecutions against persons who are unregistered and who may have committed offences under the legislation. That is a broadbrush idea of what the registration function involves.

A brief run-through of the historical context: medical practitioners were first registered in Port Phillip under a New South Wales Medical Act by the New South Wales Medical Board from 1838. In 1844 the Medical Board of the District of Port Phillip was established. In 1854 there was the first Victorian Act to make amendments to the arrangements for the Medical Board of the District of Port Phillip, and in 1862 the first Medical Practitioners' Act was passed in Victoria. If you read the historical records, it seems that the objective of the profession in seeking statutory registration was really about protection of turf and being able to control who was eligible to do medical work: who was eligible to appear as witnesses at inquests, sign death certificates or work in publicly funded medical officer roles. First the medical profession and then other professions successfully secured the backing of the state for their self-regulatory arrangements — the term often used is statutory self-regulation.

Boards at this time were made up solely of members from the profession concerned, and they were the elite members of the profession. They were uniformly white, Anglo-Saxon men. The market shelter that registration created, combined with the rise of scientific medicine, meant that the medical profession secured a position at the peak of the division of labour in health care and was able to control to a certain extent what other members of other professions were able to do. Registration for those other professions was generally very hard fought for, and there is evidence of medical dominance in the gatekeeping process. They generally only obtained registration when they reached a settlement with the medical profession.

The next slide gives you a snapshot of when the different professions were first regulated in Victoria. There are significant differences across jurisdictions in terms of timing of registration, and so it really depended on local factors as to when statutory registration legislation was passed in each state and territory. By 2010 we had what were called eight partially regulated professions, in addition to the nine professions that were subject to registration regimes in every state and territory. The eight partially regulated professions had registration regimes in one or a number of jurisdictions, but not all of them. You can see Victoria regulated dieticians and then deregulated them in 1993, and dental technicians were deregulated in 1999.

The context for reform dates back to the 1980s and 1990s. The first 150 years of regulation saw very little change to the regulatory model, but since the late 1980s we have seen just about constant regulatory reform activity in this space as the state has attempted to come to grips with the pressures of cost containment and a range of factors impacting on the ability to deliver health services and the need to better organise the health system. The disadvantages of occupational licensing or statutory registration regimes became clearer in the 1980s, and at that time there were efforts to begin to harmonise the arrangements across states and territories.

In 1987 we saw the Health Department commence a review — it is often called the Carter review — that established the Victorian model of regulation, which was then progressively applied in a series of regulatory reviews throughout the 1990s to 11 other regulated health professions. In the 1990s we also had the Mutual Recognition Agreement and the National Competition Policy Agreements, both of which put pressure on to reform the regulatory arrangements. Of course we have had continuing pressure with the rise of the better regulation discourse and reducing regulatory burdens. We have had continuous regulatory reform processes since the late 1980s.

With international trends you see a similar pattern. We have got a changing role for registration boards. They are expected to do a whole lot more than they used to do. There is a changing role for the state. The state has been increasingly willing to take on the professions and restrict the independence and professional judgement of professionals. It tries to get more public interest input into regulatory decision-making. There has been an acceleration in the level of state control of the regulatory arrangements — a progressive process — and increasing demands for transparency and accountability. The principle of peer review in the regulatory arrangements has also come under pressure.

The immediate impetus for reform that led to the National Scheme was a number of factors which combined. First was the public outcry over some fairly high-profile cases of a breakdown in professional standards, notably with Dr Patel in Queensland and Dr Reeves in New South Wales. We have had our own perhaps not quite so high-profile cases, but there have certainly been some problems. There has been continuing pressure to reform

under Competition Policy and increasing demand from the professions for greater portability of registration across state boundaries as increasing numbers of people want to do locum work interstate or are required to be registered in every state and territory because of telemedicine requirements. All of those factors have been important, but probably the most important single factor in driving the national reform has been workforce shortages, so it is about cost efficiency and cost effectiveness but not about the actual regulators themselves; it is more about the health system and how to ensure that governments have available to them the levers to drive workforce reform.

Victoria undertook a system-wide review in 2002 to 2005, and these are the key findings of that review. What we found was that we had a cumbersome and inefficient legislative framework. We had poor separation of powers in disciplinary matters. We had lack of consumer confidence in the transparency of our regulatory regime. We had inefficiency and duplication in the administrative arrangements. We had workforce inflexibility and poor practitioner-system quality linkages. We knew we had a changing population demographic. We knew we had an increasing demand for services. We knew we were having increasing difficulties with workforce shortages. So there was a need to reform the regulatory arrangements to deal with those pressures. There was also a link made at that time between workforce regulation and workforce reform.

From what I understand, the immediate trigger for the Productivity Commission was the dispute with the College of Surgeons around the restriction of training places; that led to the reference to the Productivity Commission to do a study. The Productivity Commission's findings included: fragmented roles and responsibilities; compartmentalisation of workforce policy; lack of an integrated cross-profession approach; inflexible and inconsistent regulation across states and territories; difficulties that flowed on in terms of changing professional scopes of practice — the difficulty in driving those changes to scopes of practice; and limited incentives for delegation of tasks.

In relation to the registration regimes the Productivity Commission found there were unnecessary barriers to mobility, inconsistencies in the legislative requirements, difficulties with ensuring quality, perceived failures in the peer review model of regulation and of course again that workforce shortages were projected to grow. With over 90 separate regulatory bodies across the country, their view was that a less fragmented and better coordinated system should provide the levers for governments to drive workforce reform.

The Productivity Commission recommended a series of reforms. The two reforms with respect to regulation of the health professions were the staged introduction of a single national accreditation regime and agency, and the creation of a single national registration board with supporting professional panels to provide national registration standards for the health professions.

What happened following the Productivity Commission report was that COAG commissioned senior officials to prepare a response. It was in July 2006 that response was published. What followed was the Intergovernmental Agreement that was signed in March 2008, and that set out the parameters for the scheme and then the implementation process involving the development of the legislation. The planning for the transition occurred between March 2008 and July 2012. I have said July 2012 because the final four professions only came into the scheme on 1 July. The Intergovernmental Agreement also set out the regulatory model and talked about the implementation process and made some statements about how partially regulated professions and unregistered professions should be dealt with. We then entered into another process of consultation with the various stakeholders to develop the legislation.

To give you an overview of the national scheme as it is operating now, it commenced on 1 July 2010. WA entered on 1 October of the same year, and as I said, we had four new professions enter the scheme this year.

Essentially there was a shift from multiple profession-specific state and territory based regulatory regimes to a single national regime. There was a significant change management process involved, with new legislation in every state and territory and also the Commonwealth — the Commonwealth had to deal with its interface with the National Boards and the national registration regime around Medicare and pharmaceutical benefits, veterans affairs et cetera. Over 90 registration boards were abolished and 38 separate administrations were abolished; 14 new National Boards were established, and 8 new state and territory offices and a national office, which is based in Melbourne. Over 600 staff transitioned, a new IT system was built, 1.5 million registration records were transferred, over 500 000 registrants were also transitioned and over 12 000 new registrants were grandparented into the scheme.

New national standards were established by all 14 of the National Boards, and there was a new organisation to bed down. There were new governance arrangements for jurisdictions that needed to work out the processes through which they would support the Ministerial Council to make the decisions that it needed to make under the National Law. So as you can see it was quite a sizeable change management exercise.

There were some teething problems and transition issues. Certainly bedding down a new organisation, given the pace of reform, was challenging. It was important so far as possible to retain the existing staff knowledge and skills and the existing board members. The transition of registrants and their data was a huge exercise. Part of the problems involved the lack of consistency of the data — how it was described, how it was maintained, the IT systems across the 90 separate boards across the country — and migrating that into one system. The accuracy of the registration data was at times problematic. The partially regulated professions had to be assessed for inclusion in the scheme.

The project team managing the process had to deal with the late entry of WA and some carve-outs in the statutory functions that New South Wales implemented to retain their complaints handling and disciplinary functions with their local councils. Also the accreditation arrangements had to be bedded down with new organisations established and conferred with powers. For the four new professions entering the scheme the new boards had to be up and running and grandparenting of those practitioners into the scheme had to take place.

On the structure of NRAS, the slide I have put up is the simple version. You can see each of the main elements in what constitutes the National Registration and Accreditation Scheme. Off to the side you have the Advisory Council, which is a council that advises the Ministerial Council on matters to do with the health workforce. You have got the 14 National Boards and you have got the Agency Management Committee, the national office, national committees and state and territory or regional boards of the National Boards. You can see down the bottom those lines that indicate the nature of the relationships between those entities. That is the simple version.

The next slide — I am afraid you cannot read it very well — is the more complex version. We did not put all the lines in, as Peter might have liked, because it would have looked like a, you know — —

Mr FITZGERALD — This is the Hydra-headed monster.

Ms CARLTON — That is right. But if you think that is complicated, we did have a chart that showed the existing arrangements prior to the establishment of the national scheme, and it did not fit on one page. If you can imagine there were 90 separate boards and 38 separate organisations. This is relatively straightforward compared to the previous arrangements.

I just wanted to make a couple of comments on the legislative model. It is important to get your heads around this because it is an unusual model. It has not been used very often. The scheme operates in Victoria under Victorian law, not Commonwealth law. It is a national scheme, not a Commonwealth scheme, although the commonwealth does have a seat at the table on the Ministerial Council, but the participating jurisdictions are all eight states and territories, not the Commonwealth.

There were various options canvassed during the development of the scheme as to the legislative mechanism: referral of powers to the Commonwealth; complementary legislation; and the option that was ultimately adopted, which was adoption of laws or incorporation by reference, which involves one jurisdiction being the lead jurisdiction that legislates the principle provisions of the act and then the other jurisdictions that pass legislation to adopt and apply that law as a law of their jurisdiction.

The Victorian Act, you will see, has got a front part, which is Victoria's adoption law, and then what is attached to that adoption law is the schedule, which is the law that was passed in Queensland, which was the lead jurisdiction in this model. The implementation went in three phases: Act A to establish the structural elements of the scheme; Act B to enact all the principle provisions; and then Act C in every state and territory to adopt and apply Act B, which was the Queensland Act.

There are many interfaces that had to be dealt with in the legislative model, and they have been dealt with differently, depending on the circumstances. When it comes to statutory interpretation and accountability and reporting, there are tailor-made provisions in the National Law. When it comes to privacy, FOI and Ombudsman powers, Commonwealth laws have been applied, but there is a National Health Practitioner, Ombudsman and Privacy Commissioner who exercise those powers — two statutory officers, appointed by the

Ministerial Council — and then there are state and territory laws that apply with respect to records, drugs and poisons, the authorities to prescribe, tribunals, courts, administrative review et cetera. Then there are slightly different arrangements in New South Wales — they are called co-regulatory arrangements — which I will not go into.

Under the governance arrangements for the scheme the Ministerial Council approves legislative changes, provides policy directions to the boards and the agency, appoints the National Boards and the agency management committee and grants final approval of registration standards, which are the standards that are set for entry to a profession that are developed by the National Boards. There is no role for the Ministerial Council in individual registration and accreditation decisions.

Then you have got the National Boards that are responsible for oversighting the development of registration standards. They oversight the accreditation functions, they decide on what committees are needed to exercise their functions — the big professions have state and territory committees, the small professions just operate through national committees. The National Boards have flexible delegation powers and they provide policy advice directly to the ministerial council.

The agency provides operational support to the National Boards and their committees, maintains the national registers, must agree the fees per profession with each of the national boards and sets business rules for the development of professional standards and other operations of the National Boards.

The Advisory Council advises the Ministerial Council on matters that are referred to it, and the accreditation bodies were initially assigned their functions by the Ministerial Council but are now reporting directly to each of the National Boards. In 11 cases there are external accreditation bodies and in three cases there are internal accreditation committees.

Those are the professions that are regulated under the national scheme, and the profession of paramedics is currently under assessment. There is a COAG regulatory impact assessment process under way being led by Western Australia.

There is some data for you. I will not go into too much detail other than to say that there are 150 000-plus registered practitioners in Victoria out of a total of 577 000 nationally. There is lots of data in the annual reports on the registration function and also complaints handling and discipline.

That is a screenshot of a certificate of registration, so boards still grant certificates of registration, and also, if you ever feel the need to log on to the AHPRA website, you can click on, check the register, enter somebody's name and details will come up.

I do not think I will go into too much detail about the complaints-handling and disciplinary regime other than to say that there are some elements that have strengthened public protection compared with the previous Victorian arrangements, and they include an expansion of the mandatory notification requirements that are imposed on practitioners and employers.

The relationship with health complaints entities, the health services commissioner, is pretty much the same as it used to be. There are three basic pathways for dealing with matters: performance, conduct and health, and the tribunal — in our case, VCAT — has both original and review jurisdiction, depending on the matter. There are a range of offences under the National Law for unregistered persons who hold themselves out as being qualified to practise or registered under the National Law. In terms of comparisons with previous Victorian arrangements, although other jurisdictions might not agree with us, the National Law is modelled relatively closely on the Health Professions Registration Act. The same range of powers and functions are conferred on the National Boards as were conferred on previous Victorian boards. It has got a different drafting style, so it looks different and feels different.

There are changes to the registration categories. There is specialist registration and the endorsement powers, but it is essentially the same approach. As I mentioned, there are some strengthened public protection measures around criminal history checking, mandatory reporting, English language requirements, how checking of registration status is done and how often, and there are some stronger enforcement powers; but those changes are around the edges. One significant change in my view is the chairing of the National Boards. Now the boards can only be chaired by a registered practitioner from the profession, whereas under previous Victorian

arrangements any member of the board could be in the chairing role and with some boards there were community members who were chairing the boards.

There have been some changes to ministerial powers, and obviously those powers are now exercised by the Ministerial Council, so Ministers have to reach agreement. There have also been some changes to the way pharmacies are regulated, with a split of responsibilities, with some going national and some staying at the state level.

Certainly there were issues to begin with, but many of those issues have been sorted through. Are there still matters to address? There are; some of them are the structural arrangements for accreditation. With these multiple separate accreditation bodies it is an expensive way to operate the accreditation functions. In relation to the arrangements for the Aboriginal and Torres Strait Islander health practitioners, we only have I think about four or maybe two registered practitioners in Victoria, most are in Northern Territory, with a smattering in other states, so there are issues to do with the viability of that board which need to be sorted through.

In relation to the issue of whether boards should have continuing competence powers — powers to require evidence of continuing competence as a condition of renewal of registration — I know the Medical Board put that issue on the agenda; it was on the front page of *The Age* last week. So some might say there is a gap in the legislation in respect of the Boards' powers. There is also some streamlining that could take place with respect to the state and territory boards of the National Boards to operate more efficiently.

The role of community members is an issue that I think the Minister has mentioned previously, and of course in relation to dealing with jurisdictional disputes that arise from time to time between professions that play out in the regulatory arrangements there is also scope to do that a bit better, as there is with governance arrangements at the jurisdictional level to support the Ministerial Council in making decisions under the scheme, particularly around conferring prescribing rights, but in other areas as well, such as approving specialties and that sort of thing.

The interface with drugs and poisons legislation and how the authorities are conferred on practitioners is an area that needs further work. With regard to the role of the Advisory Council, which you saw in the structure of the scheme, it has not had much work to do since it has been established, so there are questions about that. The provision of data from the registration regime for workforce planning processes, and prohibition order powers for tribunals and how they work are some of the matters we may address in our submission.

There are quite a few issues where there is scope for some reform, including the interface with the health complaints entities and how alternative dispute resolution processes might operate within the regime; the right of review for notifiers, which notifiers under the Victorian arrangements certainly had but it did not flow through to the national scheme; and offences for deregistered practitioners who breach prohibition orders that have been imposed by a tribunal.

Finally, we have put together a package of information for you. The first item is an issues paper that was published by the Australian Medical Council in 2001 that really put the issue of national registration on the public agenda. Then there was the 2003 discussion paper issued by the Department of Human Services. We put that in because it has got a lot of data on the registration regime and how it operated in Victoria prior to the national scheme, and there is the 2005 paper that set out the template for reform that was then enacted with the Health Professions Registration Act, so if you are looking to compare the national scheme with previous arrangements there is some information you could draw from.

There is the 2005 Productivity Commission report and the Intergovernmental Agreement that underpins the scheme. There is a whole list of consultation papers. We have not included them; we have just included a list of what they are. They were papers published during the development of the scheme where consultations were carried out on the various elements of the scheme. We also have a copy of the Senate Finance and Public Administration References Committee Inquiry — just the contents lists; I think you have probably got access to that anyway. And the Productivity Commission has recently published a report looking at the impact of the national scheme, as one of the elements of the COAG reforms and whether there have been productivity savings as a result. That is included in your package, and there are the two documents that Peter referred to from the UK — one of which we still need to get hold of and we will forward to you.

The CHAIR — Ms Carlton and Mr Fitzgerald, thank you very much for that comprehensive background briefing. That historical context is also very useful for those of us who are not practitioners, so we greatly appreciate that.

Mr VINEY — There has been a lot of reform in the health sector in the last 10 years. Mr Fitzgerald, my understanding of your role is that you head the strategy and policy division and so you have responsibility for improving the Victorian health system through policy reform, strategy development and regulatory activities et cetera. I take it that in regard to this whole process of reform, while Anne-Louise is obviously responsible specifically in this area, you have the overarching responsibility for all of the policy reforms that have been happening in the health sector of which this is a part.

Mr FITZGERALD — Yes.

Mr VINEY — I think you prepared a PowerPoint presentation in terms of the national reform agenda program which you used as an exercise in explaining the national reform agenda process. You prepared it in August of 2011, is that right? Is the document I found on the department's website the one you have mainly been using?

Mr FITZGERALD — If it was on the department's website, yes. I have lots of PowerPoint presentations. We do at least one month on the national reform.

Mr VINEY — Yes, I am sure. Is this one in August of last year still relevant? That was prepared at the time that the agreement was signed.

Mr FITZGERALD — The national health reform agreement was signed in August 2011.

Mr VINEY — And was this used as the exercise to explain all of that through the department?

Mr FITZGERALD — Yes.

Mr VINEY — So that is still quite relevant, because the reform agenda has not actually changed since then, has it? There have been no major changes to the agreement as it was in 2011.

Mr FITZGERALD — No.

Mr VINEY — During those COAG negotiations did Victoria ask any questions in relation to the use of the five-year average of the Australian Institute of Health and Welfare health price index, the population growth estimates weighted for hospital utilisation and the Productivity Commission derived index of technology growth for calculating the amount of funding Victoria ultimately receives? Was that questioned in those negotiations? You would have been central to that whole process of negotiation.

The CHAIR — Before you answer that question, Mr Fitzgerald, I give you the discretion to answer the question if you wish, but you are principally here to deal with questions in relation to our terms of reference. Whilst I do not profess to be an expert in this area — —

Mr O'BRIEN — I am happy to take point of order on how it is relevant to the terms of reference.

Mr VINEY — It is actually relevant to our standing orders, Chair. Standing order 23.02(4)(a) states:

> Legislation committees may inquire into, hold public hearings, consider and report on any bills or draft bills referred to them by the Legislative Council, annual reports, estimates of expenditure or other documents laid before the Legislative Council …

I point out that page 19 of the annual report of the Department of Health says:

> Victoria played a major role in the new national health arrangements, with a new national agreement signed in August 2011.

So in accordance with the standing orders and in accordance with what is in the annual report I am using this opportunity to ask the man who has been central to all of those negotiations on behalf of the department to clarify some matters that are of very significant interest to the community at the moment. That is part of our remit. We have the department here — why not pursue the question?

Mr O'BRIEN — In Mr Viney's answer I think he has actually confirmed that his question is wholly outside the terms of reference. In fact it is premised on a totally different report to the one that comprises the reference to this committee. If I can continue with my point of order. I heard Mr Viney's response to the point of order. The two reports that comprise the terms of reference for this reference are the 2009–10 and the 2010–11 reports of the Australian Health Practitioner Regulation Agency, not the health department's annual report, so it is wholly outside the terms of reference

The CHAIR — I am happy to rule on the issue.

Mr VINEY — You cannot.

The CHAIR — Actually, Mr Viney, I can. I reiterate my thanks to both of you for appearing here tonight and for giving your time in what is a background briefing for this committee to come up to speed with the historical issues associated with this reference. Mr Fitzgerald, I require you to answer questions that are related to the terms of reference before this committee, but you are under no obligation to answer any other questions. I rule the question out of order.

Mr VINEY — You cannot; you do not have the authority to silence me. The only way that I can be silenced by this committee is by resolution of the committee that I be no longer heard. You do not have the power as the Chair of this committee to rule me in or out of order. The standing orders allow me to ask questions of departmental people in relation to an annual report. That is what I am seeking to do.

Mr O'BRIEN — That is not the reference.

Mr VINEY — This is a public hearing of the committee, and we can pursue the issues that are in our remit as a committee. That is clearly in the standing orders.

Mr O'BRIEN — I have made a point of order that that is out of order.

Mr VINEY — The witness told us that this is part of a very large program of reform that has been happening in health, and I am wanting to pursue some other issues.

The CHAIR — I have given a ruling on the matter.

Ms CROZIER — I thank you for the very extensive and concise presentation that you have given us in relation to AHPRA. As the Chair has pointed out, it was very helpful to the committee to understand the issues surrounding what this inquiry is looking into. I have a question in relation to the health programs. As a former practitioner myself — I was first registered in the early 1980s and have not been registered since 2010, so I have not come under the new scheme and have no knowledge of the transition issues directly, but I am very aware of them and I think most of them have been ironed out — I want to go to the heart of the health programs because that is something that I am very familiar with.

I think you said, Mr Fitzgerald, that Victoria had led the way or was ahead in relation to those health programs, that there was not the same impetus at a national level and that this was a key issue for doctors and nurses. I think, based on my own experience, that goes to the heart of a lot of the issues around the registration process. I am wondering what their concerns are. Would you be able to elaborate or give information to the committee in relation to those particular concerns that they might have and what you think they would need going into the future? Do you have any feedback from those two professional entities?

Mr FITZGERALD — I can say that we might need to take some of this on notice. It is something I think should be the subject of substantive briefing.

Ms CROZIER — I am very happy with that, if that is all right, Chair.

Mr FITZGERALD — If I can phrase the issues in general terms which is that the funding of those programs was guaranteed for an initial period of time. They are now up for renewal in terms of their long-term future as to whether they will be funded via the national scheme for the ongoing operation of those programs or whether they will be discontinued or funded in some other way.

Ms HARTLAND — Thank you for the briefing. I have been concerned all along that this reference may have already been done in other places and that the minister is doing this just to keep this committee busy — you do not have to answer that — rather than actually giving us references that are relevant.

I am just looking at the relevant resources and I notice there has actually been the commonwealth Parliament 2011 Senate Finance and Public Administration References Committee inquiry into the administration of health practitioner registration by AHPRA and the Productivity Commission 2012 research report, *Impacts of COAG Reforms — Business Regulation and VET*. I am not sure that you can answer this tonight, but I am wondering whether this work has already been done in those two inquiries?

Mr FITZGERALD — I think I can say that the recent Productivity Commission report is not substantially related to the national health practitioner registration accreditation scheme; it is a broader inquiry as to business regulation. I do not believe that they have done a methodology to test cost effectiveness or efficacy.

The 2011 Senate committee report related most specifically to the launch of the national scheme and some of the teething issues, and was therefore not a three-year operational review as to how things were going or whether the objectives were being met. It more specifically related to some issues around the beginning of the scheme.

Ms HARTLAND — If I could follow on, Chair, are you aware of any other work within the department or in any other state where a similar reference is being looked at or whether what we are being asked to do here has already been done? I would be a bit surprised if it had not been.

Mr FITZGERALD — I think I can say that I am not aware of any.

Ms CARLTON — No. I think the intergovernmental agreement makes provision for a review at the end of three years of operation of the scheme. Certainly some of the issues that are addressed in your reference overlap with what may well be addressed in the three-year review. Of course the Productivity Commission reference to revisit its 2005 report will include revisiting those aspects that relate to this scheme.

Ms HARTLAND — When will the three-year review begin?

Ms CARLTON — It has to be done after three years of operation of the scheme. The earliest it can start is July 2013, and certainly there are draft terms of reference that are being looked at by jurisdictions at present.

Ms HARTLAND — Is it possible for us to have a look at those draft terms of reference?

Mr FITZGERALD — I know that there is some confidentiality around working drafts in this regard, because there is a bit of work to be done on refining them. We will take that on notice as to whether we can. Certainly once the review kicks off it will be public. I think it is probably a bit like draft terms of reference for parliamentary inquiries. They are tossed around but they are not necessarily made public until they are well developed.

If I can just qualify Anne-Louise's comment, the review is called for after the operation over three years. The review might kick off in anticipation of the three years ticking over in the middle of next year, but we will have to get some better information on the exact timing of that.

Mr VINEY — When you consider that you might like to consider the fact that the committee does have the power to require documents to be provided.

Mr O'BRIEN — Thank you for your comprehensive briefing to this inquiry, which I think is an important inquiry from the details you have provided to us, particularly the 1200 meetings that are occurring. It seems to be a long way from a single, national registration body. I think your description was 'multi-headed hydra'. The 2010–11 annual report of AHPRA, which is in our terms of reference, mentions on page 13:

> The initial implementation of the national scheme proved challenging, with new systems, a new law, significant uncertainty among the practitioners about the implications of national registration …

You have touched on this. Can you just take us through some of those challenges that you faced in the implementation and what particularly the practitioners of the various professions were saying?

Mr FITZGERALD — If I can, I will give a bit of a feel for the issues that were raised at the Senate committee. When the scheme kicked off and there was national registration for the first time, there were issues with systems, call centres, and the responsiveness of the people answering the phones in being able to solve the problems. As could be imagined, moving tens of thousands and then hundreds of thousands of registrations to a new scheme with a new set of people to answer phones and queries turned out to have a large delay component to it in the first period of time. I do not have the direct quotes from the Senate committee, but that was canvassed there.

Mr O'BRIEN — I have one I would like to put to you. It is paragraph 4.3 in chapter 4, and I have the submission here. The quote from the Senate committee is:

> The cost shift is to the professions, the burden shift is to the professions, the anxiety shift is to the professions and it does not take much to work out how people have lost confidence.

Could you take us through that issue and to what extent it still exists?

Mr FITZGERALD — I think that probably the questions might better be directed to APHRA as an agency. To be clear, the department has a role in advising the health minister. We have a role in advising the minister and overseeing the legislative arrangements, and we have an interest in the successful operation of the scheme. APHRA does not necessarily report to the department as an agency of the state government. It is a national agency. However, the interest that we do have means that we are in every day contact — I say every day, but it is probably not every day; a constant degree of contact. We were aware of what we call 'teething problems' but they were very substantial problems for the registrants.

Mr O'BRIEN — I will give you another quote to comment on:

> The AMA wants to impress upon the committee that the management of the transition from state-based registration to national registration has been an absolute debacle.

That is pretty strong language.

Mr FITZGERALD — No. I think there is no doubting that is a summation that professionals made at the time. I believe there are now indicators of the responsiveness, and I think we will look back at the initial period of time as a particular hump that was substantially addressed. I am not saying that there are not delays and whatnot now, but I think the order of dimension is substantially different. But I think it is a fair line of inquiry for this committee to get some more evidence on it.

Mr O'BRIEN — It seems with 1200 meetings there is still a bit to go.

Mr VINEY — That is four questions tonight.

Mr O'BRIEN — I am happy to give someone else a go.

Ms MIKAKOS — Are you done?

Mr O'BRIEN — I had one more but I will let you go. I understand I have had a fair go.

Ms MIKAKOS — Ms Hartland articulated earlier the concern that I had also about the duplication of this inquiry with other inquiries. I want you to clarify, if you could, Mr Fitzgerald, who will conduct the three-year operational review and will there be opportunities for various professions to make submissions, including the department itself?

Mr FITZGERALD — The review will be auspiced by the Council of Australian Governments Standing Committee on Health and the Australian Health Workforce Ministerial Council. The precise shape of the review, whether it is a panel, an individual or some other arrangement, has not been settled. The terms of reference, as we say, are in the early stages of drafting. It is the expectation that there would be public submissions and that there would be opportunities for the professions to have input into it.

Ms MIKAKOS — I believe you said earlier in your presentation that there was also going to be a further Productivity Commission review into the same subject matter next year.

Mr FITZGERALD — Yes.

Ms MIKAKOS — Presumably that will also be an opportunity for public submissions, so the stakeholders are going to be very busy writing submissions. I just see this inquiry as a bit of a waste of time really, because I think where we are going here, and Mr O'Brien is suggesting through his questioning, is that somehow this committee would recommend to the Victorian minister that we opt out of this stand.

Mr O'BRIEN — I was a long away from any recommendation. I just asked.

Ms MIKAKOS — I find it quite bizarre where your line of questioning is going with that, Mr O'Brien.

Mr O'BRIEN — The word was 'debacle'.

Ms MIKAKOS — Anyway I think the key issue here is that within a 12-month period we are going to have three inquiries — two national ones and a Victorian one — and there was a Senate report last year.

Mr O'BRIEN — Where is your question?

Ms MIKAKOS — Essentially what I am asking is: where is the value in the Victorian parliamentary committee looking at something that is going to be covered by two national reviews. I realise I am putting you in a difficult position in terms of answering that, but — —

Ms HARTLAND — It is probably a question for the minister.

Ms MIKAKOS — It is a question for the minister, but I think it is quite bizarre that we are embarking upon this inquiry that is just going to duplicate a whole lot of other work and we are going to have stakeholders writing the same submissions to presumably two or three bodies. It makes no sense.

The CHAIR — Feel free to respond if you wish to.

Mr FITZGERALD — If I can just maybe observe that Parliament in its wisdom has a set of terms of reference, and it is quite appropriate for the Victorian Parliament to have a view — —

Mr VINEY — Well, 21 to 19.

Mr FITZGERALD — It is a piece of legislation that belongs to this Parliament. It does present itself as an issue in the national scheme in which it is appropriate for jurisdictions — states and territories — to say, 'Is it working for us?'. I think the Productivity Commission will have a particular perspective, but it will be a national perspective, so I think it is appropriate that the Victorian Parliament address the issues that it thinks relevant to the scheme.

Ms MIKAKOS — But presumably Victoria will put its view to those two national reviews.

Mr FITZGERALD — I suspect that will be the case. It will certainly be more the case in relation to the Ministerial Council-led review that the minister will be a recipient of the review rather than necessarily a direct participant in that respect, so that will be different in that regard.

The CHAIR — I am conscious of time — that we scheduled this hearing from 8.00 p.m. to 9.00 p.m. and it is now 9.21 p.m. — but I am happy to take a couple of final questions.

Mrs PETROVICH — Thank you very much for your presentation. I am not involved in health in any way, and to be honest it was very enlightening. It is obviously a very cumbersome system, and it should be a very interesting inquiry.

One of the very first points that was raised was about comparisons with other jurisdictions and some of the work that is being done internationally. You talked about jurisdictions in Canada, Britain et cetera. The UK has done a performance review of its system recently, you mentioned, and we obviously have an exchange of health professionals here in Victoria — we have many international doctors who do a very good job for us. My question is twofold: how is our system viewed internationally and what does our system provide — do we provide those services for those international professionals?

Ms CARLTON — How is our system viewed internationally, meaning our regulatory regime?

Mrs PETROVICH — Yes.

Ms CARLTON — It is very hard to answer that question.

Mrs PETROVICH — Does it compare, I suppose?

Ms CARLTON — Does it compare? I think that the ranges of functions that these regimes carry out are fairly similar and there is a similarity in a lot of the language that is used. I think the UK is comparable because a number of its regulators are about the same size as the national registration scheme, and those reports were published only two or three weeks ago, so they are very recent reports. But as to how our regime is viewed, I have to say that the chair of the Health Professions Council, the second-largest regulator in the UK, which is an umbrella regulator which regulates 15 or 16 professions, visited here in February and has been in regular contact ever since, so there is obviously a sharing of regulatory issues and understandings and a dialogue that has been going on. But how they view our system — —

Mrs PETROVICH — You do not know whether they have a view of our system in the UK?

Ms CARLTON — I could not speak with authority on that.

Mrs PETROVICH — So how does AHPRA service those international doctors? Does it assist them?

Ms CARLTON — I think there is a lot of work going on in this space to streamline the pathways through which international medical graduates and graduates of other professions enter the Australian health system and obtain registration.

Mr FITZGERALD — I think it is fair to say that it is a challenge and a large component of some of their challenges. Australia does have a much higher percentage of our health professionals who were qualified in other countries. It is a destination of choice in terms of those who want to get registration in a foreign nation, so we have a lot more foreign registrants than the number who actually come into the country. There is a phenomenon there. Again it is one of those areas in which a bit more detail might be useful.

Mrs PETROVICH — So those statistics are not necessarily available?

Mr FITZGERALD — I think they are gettable; I do not think they are in the standard publications. I must say I have raised the same issue myself as a general proposition: just how active is the international registration and how well is it working? We certainly hear that it is a challenge for them.

Mrs PETROVICH — In your view are we comparable with others internationally?

Mr FITZGERALD — It is too broad a question to ask. We might say against a set of western countries, very similar.

Mrs PETROVICH — What about the UK, because it has just done its review?

Mr FITZGERALD — Yes, I think we are similar. If I can just use one dimension, you need a criminal check to be an active practitioner; it is not easy to do the same criminal checks as you do in Australia rapidly. It is not easy to do that with a large number of other countries to choose from.

Mr VINEY — Chair, can I ask: were you saying you are going to rule out any questions that I want to pursue in relation to the annual report of the Department of Health that relate to the national reform program?

The CHAIR — I will rule out of order questions that do not relate to the terms of reference that are before the committee.

Mr VINEY — So tell me, even though in the standing orders it is our obligation to do that, you are ruling it out on this occasion?

The CHAIR — I will rule out of order questions that do not relate to the terms of reference that are before this hearing tonight, and it is inappropriate to ambush these witnesses who have come along in good faith.

Mr VINEY — It is their annual report. Let us cut to the chase then: will you give an undertaking that you will call a meeting of this committee in February next year so that we can actually pursue these questions with the department as is required under our obligations under the standing orders to look at the numbers?

Mr O'BRIEN — On a point of order, there is no such obligation — —

The CHAIR — Mr O'Brien! The next meeting of this committee will be convened with adequate notice to all members and any potential witnesses. I declare the meeting closed. Thank you both for your attendance this evening.

Committee adjourned.