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 — 26 June 2013

Members

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

Participating members

Mr A. Elsbury
Mr S. Leane
Mr S. Ramsay

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

Staff

Secretary: Mr R. Willis

Witnesses

Mr S. Milgate, executive director,

Dr J. Buntine, committee member,

Dr S. Prager, committee member, and

Dr R. Prytula, committee member, Australian Doctors' Fund.

The CHAIR — I declare open the Legal and Social Issues Legislation Committee public hearing. Tonight's hearing is in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency. I welcome Dr John Buntine, Dr Richard Prytula, Mr Stephen Milgate, the executive director of the Australian Doctors' Fund, and Dr Shirley Prager. Thank you all for being before us this evening and for your written submission, which members have read.

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.

I now invite you to proceed with a brief opening statement, if you wish, which will be followed by members' questions. I note that two members are not here at the moment, but they may be coming in due course.

Mr MILGATE — That is fine. We understand.

The CHAIR — You understand the circumstances.

Mr MILGATE — Yes. Absolutely.

The CHAIR — If you could proceed, thank you very much.

Mr MILGATE — Madam Chair and members of the committee, the Australian Doctors' Fund welcomes the opportunity to present its case to the Victorian Legislative Council on the performance of AHPRA. The ADF submission merely points to the inherent flaws and weaknesses in handing over registration and discipline of health professionals to a bureaucracy which has nine owners and therefore no effective ownership and accountability. Furthermore, the ADF maintains that the so-called efficiencies of this model have not and will never eventuate. Rather, the model facilitates open-ended growth of costly activities and regulatory burdens which add nothing to effective patient care.

Today Dr Richard Prytula, on my right, a director of the ADF, will outline briefly the financial performance of AHPRA and its failure to deliver cost-effective registration for the 91 000 doctors registered with it. Dr Prytula is a practising psychiatrist in Melbourne with a particular interest in corporate governance and is also a graduate of the Australian Institute of Company Directors and a past president of the college of psychiatrists, who were involved in discussions when AHPRA was first established.

On my left is Dr Shirley Prager, also a director of the ADF and a practising psychiatrist in Melbourne, who will express her concerns over the programs for impaired physicians under the AHPRA model. We will then be happy to answer questions.

In summary, we are recommending a return to the Victorian medical board model, or as it was called the Medical Practitioners Board of Victoria, with sufficient resources to operate a register of medical practitioners and the disciplinary functions required. We note that the Queensland Parliament will soon legislate to amend the national law and return the disciplinary functions previously exercised by AHPRA for health practitioners back to Queensland government control.

In presenting its case, the ADF draws attention to the work of Professor Gerard Carney, professor of law at Curtin University, who is described as a leading constitutional expert. In his book *The Constitutional Systems of the Australian States and Territories* Professor Carney wrote:

> A risk of many commonwealth and state cooperative schemes is 'executive federalism'; that is, the executive branches formulate and manage these schemes to the exclusion of the legislatures. While many schemes require legislative approval, the opportunity for adequate legislative scrutiny is often lacking, with considerable executive pressure to merely ratify the scheme without question.
>
> Thereafter, in an extreme case, the power to amend the scheme may even rest entirely with a joint executive authority. Other instances of concern include, for example, where a government lacks the authority to respond to or the capacity to distance itself from the actions of a joint commonwealth and state regulatory authority. Public scrutiny is also hampered when the details of such schemes are not made publicly available. For these reasons, a recurring criticism, at least since the report of the Coombs royal commission in 1977, is the tendency of cooperative arrangements to undermine the principle of responsible government.

He wrote that in 2006. The ADF believes that all functions of registration and regulation would be more efficient if they were returned to state government control. Simply, AHPRA is overly complex, costly and unnecessary. Dr Prager will now read her statement.

Dr PRAGER — The Australian Doctors' Fund is concerned about the detrimental effects of the AHPRA mandatory reporting regulation. As a consequence of this regulation medical practitioners are inhibited from seeking medical advice, diagnosis and treatment, fearing that they will be reported to AHPRA. The result of a notification to AHPRA is that many medical practitioners suffer stress and stigma, despite AHPRA concluding after investigation that no action is required in the majority of cases. The ill medical practitioner is denied early and often very effective treatment. Thus the medical condition may deteriorate, putting both the doctor and the public at further risk.

An example: a medical practitioner recognises that he or she is depressed at an early stage of development of the illness. Because of the doctor's reluctance to access advice and/or treatment, the illness of major depression increases in severity and the doctor suicides. I have provided references. Another example: a medical practitioner who is undergoing treatment finds that his or her treating psychiatrist has reported him or her under the mandatory reporting regulation. The patient, who may have been willing to suspend medical practice until his or her recovery from illness, commits suicide. I have provided another reference.

Although AHPRA declares that the threshold for mandatory reporting is high, that is not how the regulation is interpreted by the medical profession or indeed other health practitioners. The nature of good medical practice is to be risk averse, and thus reporting tends to occur at what would seem a low threshold to the layperson. Mandatory reporting has also been misused, with a proportion of notifications motivated by reasons other than patient safety. Thus the ADF recommends a return to the traditional state-based Victorian medical board, with voluntary notification only. This is likely to promote the early treatment of impaired medical practitioners, thereby reducing risk to the public. Furthermore, it will also be beneficial to the early treatment and recovery of the ill medical practitioner.

Dr PRYTULA — I am going to look, or try to look, principally at the financials of AHPRA, although I am limited to some extent because the annual report is the basic reference at the moment and it does not provide anything other than subtotals. So I am restricted more to generalities about AHPRA, its inception and its progress in the four or five years, roughly, since it has begun.

Let me say at the outset that I was part of the committee that was a combined medical colleges presidency group that met with members of the AHPRA formation committee. While there was some concern on the part of the colleges, the general opinion was that there would not be a concerted opposition, but rather that we would try to work with it. That has been the approach so far — what you might consider to be a very conservative, typically medical approach, which has some good aspects to it. But now looking back five years later I think there are some things to be concerned about.

I would say a number of things to start with. First of all, there was no real compelling case that we could see for the inception of AHPRA. All the functions that it was meant to represent and develop had been carried out successfully at the state level — in consideration of the Victorian case. I will speak mainly about Victoria, although I do know something about the other states, particularly New South Wales and South Australia.

This now multilayered organisation has been developed with large amounts of finance involved. It originally began as a regulatory body — in other words, it collected subscriptions. It then morphed into an accreditation body, but if you look carefully, the accreditation of the colleges, of hospitals and of training programs in medicine, through all the 12 specialties, was already being carried out by the Australian Medical Council, which is an internationally reputed body composed of the best of the Australian medical specialist colleges personnel, and that is still the case. The AMC is still doing the accreditation on behalf of AHPRA. There has been no change, but if you read the report about AHPRA, it purports to be the accrediting body. It actually is not. It is just an overlay, and it adds a number of layers of bureaucracy, which we will talk about, have spoken about and can talk about more if you wish.

Just to look at the financials in particular, this started off as a collection agency for registrations. I am speaking about medicine in one case, but there are all the other health practitioners included as well, which I will not speak about. As soon as AHPRA came in fees immediately doubled. If we look now at their financials, we see

the total income from transactions is $160 million in one year. That is from 560 000 health practitioners. What are quoted as the numbers are 90 000 registrants who are medical practitioners, but that does not equate to 90 000 doctors who are in full-time practice. Many of them are part-time. You could say that there are probably 45 000 to 50 000 full-time doctors. Staffing costs are $76 million. This increased by 40 per cent from 2011 to 2012. Payments to suppliers, employees and others in one year were $150 million. Investments — an interesting concept for an organisation which is collecting what are essentially registration fees — were $112 million.

My point is that I am restricted in detail but the question has to be asked. This essentially is quite an empire and engine financially, providing large amounts of money, and I think we have to question whether this is actually value for money or not. In particular, I do not believe that it is, and our group does not believe that it is.

I hesitate to comment on the concept of investments in a group like this, but it does seem on the surface of it to be inappropriate. This is not a company which is producing a product, it is a collection agency for registration fees. The colleges, for example, collect fees for examination and training of doctors, but they do not consider themselves to be a group which is there to increase its amount of financial assets and backing. They work on the best minimum standards possible and keep their fees as low as possible. In this case with AHPRA the medical board registration fees, as I said, are more than double now what they were initially.

There are some questions about the ethos of the organisation. Serious questions need to be asked, I think, and there are also questions about its benefits and its accountability, which we have talked about more in detail in our submission. I would like to stop there and be happy to detail anything further if necessary.

The CHAIR — My question is probably directed to you, Mr Milgate, if you would not mind, or any one of you can answer. Since AHPRA has come into being, have investigations of medical practitioners worsened or lessened? Can you comment on that process that they undertake in relation to investigations of medical practitioners.

Mr MILGATE — We do not have any information on their activity as far as investigating practitioners is concerned. There is nothing that we can find that gives us volume or pace or scope of those investigations.

The CHAIR — You did mention the Queensland situation.

Mr MILGATE — In the Queensland situation obviously there have been substantial deficiencies uncovered by the minister, and part of the problem that we hear from the Queensland medical board, which copped a bit of criticism about this — considerable criticism — is that they were substantially underresourced, even with all this income. The medical board did not have substantial resources to do the investigations that they wanted to do. That is what we have been told. We have not investigated that issue.

We have had instances where there has been criticism from doctors. There has been suspension of doctors for professional jealousy reasons, business disputes, and a particular doctor was suspended and subsequently reinstated, but there is not a lot of information we can get about the volume of complaints, how they are investigated, how they are resolved et cetera in the reports that we have got access to.

The CHAIR — One final point in relation to the accountability that you raised. In your submission you say that it reports to nine ministers but reports to no-one. Can you elaborate a little bit on that point?

Mr MILGATE — When you try to deal with this organisation, for example, you try to deal with the medical board. We have had some dealings in relation to senior doctors, semi-retired doctors, trying to get the medical board to look at having a separate category for them so that they can have a reduced registration fee. So that is one issue. When you try to deal with that issue and you go to one state legislature, you are referred to the fact that there are eight other ministers that you have to see, and then they refer you back to AHPRA, who refers you to the board, who refers you back to the ministers. It is normally their senior staff who will tell you, 'We have got a one-ninth share of this, we cannot influence this'.

The situation is interesting in legislation. As you know, if the Parliament of any state wants to remove a regulation or disallow a regulation, they cannot do it without the majority of other states. This Parliament has no force in denying a regulation under this law unless other state parliaments, which the people of this state did not elect, allow it permission to disallow a regulation. It has to have a majority before it can disallow. I know that fact because I campaigned strongly against that when the legislation came out. Even a state Parliament cannot

override legislation without a majority view under the agreement. I would question the constitutionality of that, and I have legal advice to suggest that that may be unconstitutional under state constitutions.

We have got a situation where no state or territory health minister has any majority ownership. The only thing they can tell you is, 'We will take your concerns to a meeting of ministers or to an advisory group' and they have a long list of concerns they have to take.

If you are an average citizen of this country trying to get some redress for some issue that may have happened to you, you have no way in the world of getting any parliamentary redress to an issue. You cannot lobby nine ministers. You may have the resources to do it, but it is unlikely, whereas under the old system you could take it to your state member or upper house member, they can raise it in the house, the minister can ask the board to investigate this issue on behalf of the constituent if it warrants that investigation and the medical board has to report on that. For the average person without resources and lobby groups and so forth, the old system gave direct parliamentary accountability for their concerns, and that may have required an investigation of health practitioners in a hospital or whatever, so be it, but there is a very short line of redress.

I finish by saying the doctor, or whoever else is registering, had the medical board to register with and then the minister had oversight of the medical board. It was a very simple process: you register with the board, the minister has executive authority over that board. This process now is very convoluted, and I have put it in the submission. It is to AHPRA, then back to committees, then back-balled here, there and everywhere. As was stated by Professor Carney, once you have got this ownership, you have no effective ownership.

Ms HARTLAND — Can I follow up on this issue. I was in the Parliament before AHPRA. I was never actually approached to do what you have just described on behalf of a constituent and putting that to the health minister. I am just wondering whether you can give us any kind of numbers on how often that would have happened in Victoria, because it certainly never occurred for me, so I am just wondering how it would have happened.

Mr MILGATE — I cannot talk about Victoria but I can talk about New South Wales. The patient had an issue with a hospital in Campbelltown in New South Wales. That matter ends up at the minister's table. The minister then calls an inquiry into that issue. If the issue is concerning the registration of a health practitioner, there is an ability to go straight to the minister and ask a question on that matter. At the moment, because that is owned by nine ministers, it ends up in the AHPRA system. It is very different for an individual to access direct parliamentary accountability or anything that AHPRA controls.

Ms HARTLAND — I am not quite sure that that is right because I think — and I do not want to speak for everybody else — but if a constituent was to approach one of us and had a serious concern, I do not see why we would not approach the minister on that. So I am not sure that that is actually correct.

Mr MILGATE — You will, but if it is a matter that AHPRA is dealing with, the minister does not have control over that process. The minister has to defer to AHPRA and its processes.

Ms HARTLAND — I think that is something that we should take as a question on notice to AHPRA because I would have thought that we as MPs can still act on behalf of constituents.

The CHAIR — We can act on behalf of constituents. It is my understanding we can take complaints to the health services commission or other avenues, but I think there might be something in relation to the board process in relation to direct complaints. We can certainly take that question on notice. I might move on — —

Ms HARTLAND — Yes, I appreciate that.

Mr O'BRIEN — Can I just clarify the same point: you referred to making regulatory changes as well — that you would need the consent of the other states. I understood that to have some force perhaps. I am not sure where the second point goes to, but could you just elaborate on that first point about the regulatory changes that you would see and what process you would see taking place via AHPRA at present?

Mr MILGATE — Do you mean not the disallowed issue? The other issue?

Mr O'BRIEN — Yes, you touched on it earlier — —

Mrs PEULICH — You spoke about disallowance.

Mr O'BRIEN — Yes, disallowance.

Mr MILGATE — You want me to touch on the disallowance issue?

Mr O'BRIEN — Yes.

Mr MILGATE — Yes. This is a situation where if there is a regulation that any state parliament wants to disallow, then that disallowance cannot come into effect until the majority of other states have agreed that that disallowance can take place.

Mrs PEULICH — Does that need to go through their parliaments?

Mr MILGATE — I imagine it would, yes.

Mr O'BRIEN — It sounds like a federal constitutional change.

Mr MILGATE — The idea was that you could not amend the legislation without all the other states agreeing to that amendment.

Mr O'BRIEN — They had the Corporations Law where we have conferred powers, but in that instance it is effectively the federal government that makes changes to the legislation and then all the states adopt it at various times. Is that how this works — —

Mr MILGATE — No — —

The CHAIR — What is your question, Mr O'Brien?

Mr O'BRIEN — Is that how this works? You say the state cannot make changes, but can the federal government make changes that then get adopted?

Mr MILGATE — No, because the legislation is the template legislation out of Queensland, which was adopted by all the state legislatures. It has not been adopted by the federal Parliament; it has been adopted by the ACT Parliament.

Mr O'BRIEN — That is your point. Thank you.

The CHAIR — Mr Viney, have you got a comment?

Mr VINEY — A million, but this is not the forum to resolve these matters.

The CHAIR — Do you have a question?

Mr VINEY — Thanks. Chair, you have completely reversed the normal processes in this meeting tonight, so, yes, I do have a couple of questions.

The CHAIR — Now is your opportunity, Mr Viney.

Mr VINEY — Forget it. Ask someone else.

The CHAIR — Ms Mikakos?

Mr VINEY — No, we are not playing that game. We want to participate in this with genuine questions and not be interrupted. You did not interrupt anyone else. We have genuine questions — —

The CHAIR — If you have a question, Mr Viney, please put it.

Mr VINEY — I have a heap of questions.

The CHAIR — I have given you an opportunity. Please ask what you want to ask.

Mr VINEY — Stop interrupting!

The CHAIR — Mr Viney — —

Mr VINEY — First of all, there are a number of issues that you have raised that I think are flawed in the process in terms of the way the process of regulation and the way that the process of non-national legislation is developed. Your suggestion that this arose out of the ACT is because under model legislation there is always one state that is chosen to initiate the legislation that the others then mirror.

Mr MILGATE — Yes

Mr VINEY — So it is not that the rest of the states are following the ACT legislation but in fact that cooperatively all of the states agreed to a process and the ACT — out of that process, negotiations started. Secondly, I guess I am interested because you have really raised issues that have not been raised with us before by other agencies. You have a very different perspective. I perfectly respect your right to have that. But in order for me to understand that contextually, I just need to understand a little bit more about your organisation. Can you tell me a little bit more about the Australian Doctors' Fund and who is behind it and how you are structured?

Mr MILGATE — Yes, I am certainly happy to do that. I would like to just correct one thing. I never said this started in the ACT at all. It started in Queensland. The ACT is just one of the state or territory legislatures which adopted the template legislation that was moved out of Queensland. I would like to put on the record that under no circumstances did I say this template legislation originated in the ACT; that would be wrong.

The second thing is the Australian Doctors' Fund is a policy think tank. It has about 3000 contributors. It has been going for 21 years. It writes submissions. It gets involved in issues associated with the independence of the profession and what its contributors want it to get involved in. That may be particularly contentious issues like mandatory reporting and registration or the things that doctors are concerned about. We write these papers and submissions and submit them and speak to them. We have a committee of about 16 doctors — GPs, psychiatrists and surgeons — who meet every week and discuss medical issues. We are apolitical. We enjoy communication with all sides of the house and including, as I have said tonight, meeting with the Greens and the major parties. We are only interested in health policy.

Mr VINEY — Can you tell me who those contributors are by giving some examples? Are they doctors or are they insurance companies?

Mr MILGATE — No, they are doctor-contributors. We do not have insurance companies, we do not have sponsors, we do not have advertisers. It is the doctors who contribute.

Mr VINEY — So they are only medical practitioners?

Mr MILGATE — They are primarily medical practitioners.

Mr VINEY — I might have some other questions, but thank you.

Mr MILGATE — I am happy to take them on notice.

Mrs PETROVICH — Thank you. You have provided a very enlightening submission. Mr Viney is right: you have actually put quite a different perspective on tonight's information and I thank you for that. Around governance and transparency and oversight, obviously this organisation has a very large income stream. What is the reporting mechanism to you as shareholders? Are doctors considered shareholders? Obviously it was set up as a collection agency. What is the direct reporting and transparency of this organisation to you as shareholders?

Mr MILGATE — That is easy to answer. There is this document on the website, which is a consolidated set of accounts.

The CHAIR — On which website, Mr Milgate?

Mr MILGATE — This is on the AHPRA website.

The CHAIR — Thank you.

Mr MILGATE — Everything is through our website. The only other document we can find on medical board break-up is in fact a budget statement, which is contained as one of 23 pages in the agreement between the Medical Board of Australia and AHPRA. It is not a set of accounts as such; it is the Medical Board of Australia budget 2012–13. What that budget shows is in income the doctors paid $51 964 000, the budgeted amount, to AHPRA, and $37 million of that was handed over directly to AHPRA in expenses. We work from that.

Running a computer system for 91 000 doctors is costing nearly $41 million per year, which is about $400 per doctor. This computer system is something that all health professionals enter their own information into. It is $400 a transaction. We really do not have any insight into the overall costs of how well this is accounted for. It is on the public record. The AMA et cetera has been extremely critical of AHPRA's financial reporting. That is all we have so far.

Mrs PETROVICH — If I could just ask about a couple of further points. You talked about a very substantial amount of money which is invested — did I hear you correctly?

Dr PRYTULA — Yes, $112 million.

Mrs PETROVICH — That is $112 million invested?

Dr PRYTULA — It is listed in the annual report as the current level of investment, yes.

Mrs PETROVICH — Do we know whether that is an investment in the general sense or an investment in training or an investment in — —

Dr PRYTULA — No, these are investments in the sense of accruing income. These are investments in the sense of various financial instruments which have been purchased, presumably by AHPRA, for the purpose of accruing income, and there is an income stream of $30 million coming from — —

Sorry, no, there is a loss of $30 million in that area in this current set of financial documents, which again is eyebrow raising. I have no further information.

Mrs PEULICH — A write-down of $30 million?

Dr PRYTULA — Well, it is an outgoing — it is listed as an outgoing. It is a negative — —

Mrs PETROVICH — From the perspective of you as doctors, you are paying your fees in good faith. What do you actually get for that? From a medical practitioner's perspective, what is the benefit of AHPRA to you?

Dr PRYTULA — There is no particular benefit apart from being registered as a doctor by that body, because it is the national medical board now and a doctor needs that registration to practice and needs to be in good standing with the board, but that is effectively all.

Mrs PETROVICH — And in any other sense would this be called a monopoly?

Dr PRYTULA — It is a monopoly. Once it took over from the individual states, it became an absolute monopoly.

Mr MILGATE — Could I just add to that? I put on the record that these are financial returns for 30 June 2012, and the investment is note 4b that we are referring to — the $112 million. It is less than 90-day bank term deposits and bank term deposits greater than 90 days, so that is the instrument that we have been referring to.

Mrs PEULICH — Evidence for a different point of view from that you have presented tonight is that the national scheme has led to an improvement in the standard and consistency in registrations, greater flexibility of movement between the states and the opportunity for different health professionals to share good regulatory practice and learn from each other. How could these objectives be achieved if there were a state-based body with responsibilities for registration and discipline?

Mr MILGATE — First of all, doctors have always moved around the states. We had a particular crisis in the Bali bombings, in Darwin. Doctors have gone and flown to any disaster area without any problem whatsoever in the past; it is wrong to say there were major problems. However, there was a major check considered by our forebears — that is, if a doctor moves from interstate or moved to a new area of regulation, a new jurisdiction, questions were asked as to why that doctor was moving and what may have motivated that move, so there was an extra check at each state level where the doctor had to front up to the board and say, 'I want to be registered here', and give reasons why they wanted to be registered. Now a doctor can move around because they are simultaneously registered.

What we have got is a consistent registration database. That is just an administrative function which is just basic common sense. There was a national compendium of medical registries before, for 10 years before AHPRA, that was never referred to in the case for AHPRA — it was conveniently not referred to. It did have problems because it did not all integrate and it was a computer system that did need a major upgrade, but there is no question that we could have had mutual recognition with an upgraded computer system, a database, for a fraction of the cost.

Then there is the question about national standards for other groups. We cannot speak for other groups; they have to speak for themselves. It would be audacious of us to do so. However, I think it has to be remembered — and I have quoted Professor Paul Komesaroff, an eminent Victorian doctor, in our submission — that there is diversity between groups. They do have different and special roles in the health system and one size does not always fit all, so mindless uniformity is a hazard for people.

One of the issues I want to draw your attention to is the definition of 'practice'. The definition of 'practice' is very wide, and it essentially means that a doctor or a nurse or anybody else who is discussing their knowledge is in fact practising their profession, and if they are not registered, that is against the law. Because you have these broad definitions, you do have some issues associated with trying to conform when there are special and different needs of the various professions and occupations.

Dr PRYTULA — There was something else you said that I would like to comment on, if I could. We do hear this sort of comment about AHPRA, not necessarily your words but there is something about its mission statement and its reason for being and so on, and we hear about these things, but I would actually like to dissect what you have said.

Standards? Standards are initially set by the colleges in the quality of their training. They are monitored by the AMC. Standards of practice are set by the medical board according to its mandate for doing no harm to the public on a medical basis, and that is fairly straightforward, but that has not changed since the previous Victorian medical board was in place — it was a very good organisation.

Flexibility of movement? I hear a lot about this, but I have yet to see these doctors who move so much. I think that is a very small proportion of doctors. It is used as an example of some of the benefit of AHPRA, but the only thing I can think of there is that maybe some doctors live in Victoria and New South Wales, such as in an Albury-Wodonga complex, and want to move across the river, but in actual fact they do not — they work in their town and they stay there. Some of the forensic psychiatrists, for example, are asked to give independent opinions in another state because they are at arm's length, yes, but they earn enough that they could previously have easily paid two registrations, just as I would if I had a car registered in each of two states. I do not see the purpose of having a national registration authority just because I may want to maintain a car in New South Wales as well as in Victoria, so I do not believe that is realistic. I think probably 0.1 per cent of all the medical workforce is moving across boundaries. The last thing is learning from each other. That sounds really good, I must say, but — —

Mrs PEULICH — I am just putting it to you and giving you the opportunity.

Dr PRYTULA — I would like to hear the substance of exactly what it is that this has achieved, not just that it is an aim. It is an ideal aim, but what has it achieved? How is it achieving it? Because I really do not know anything about it. I have no information, and I am fairly well connected in the specialties through the other specialist colleges and so on. I do not know anything about this. Certainly in medicine I do not think it is happening.

Mrs PEULICH — Just a follow-up question, if I may, and I accept your concerns about the unresponsive, unaccountable structure that AHPRA appears to have become, according to the evidence that you have provided. If a state-based body were established, is there a way that its functions could be split? Say, if you take away registration and administration — a disciplinary function — what else would remain, given your answer?

Mr MILGATE — This is the situation in Queensland. They are going to have a hybrid model. At the moment they are leaving registration with AHPRA and then they are taking the disciplinary proceedings back.

Mrs PEULICH — They are splitting the function?

Mr MILGATE — Yes. We believe that is unsatisfactory. We think they should take the registration function and the disciplinary function — all of the functions. That is what our submission says. There is no reason why the computer system that has been developed cannot be used by the board, and an upgraded board, an empowered board to undertake those things.

We have to understand now that the state ex-medical boards, now committees, do work. They do the work; AHPRA sends it down to them. They have not been abolished. They are there working away. We have just got this overlay that produces papers and policies and is talking about the re-examination of all the health practitioners now and is wanting to go into this area and go into that area to have a look at this and have a look at that. These groups are still working away; they just do not have the budget they used to have. They had to hand all their assets and budgetary functions to a central bureaucracy of which their state has a one-ninth share and then they have a trickle-down effect.

There is an interesting amount there that the other boards costs of the $51 million are $1.2 million. On these figures, they are not receiving vast amounts of money to undertake the work they are doing. It worked before — with a better computer system and a properly resourced function and coordination. You had the presidents of every medical board meeting under the AMC as the joint committee of medical board presidents. We had a national board for 10 years. We had a national compendium of medical registries. When I say 'we', I mean the medical profession; I cannot speak for the other professions. It was all there. It needed upgrading. For a fraction of the cost, empower the state boards and you would not have had the turmoil that you had. There was so much turmoil that there was a Senate inquiry.

The CHAIR — We are aware of that. I need to move on to Mr Viney, because we are fast running out of time.

Mr VINEY — Presumably when you raise funds, whether it is a levy or a donation or however it is done, in hundreds of dollars or maybe thousands of dollars that is provided to your organisation but you would expend money over the course of the 12-month period.

Mr MILGATE — Yes.

Mr VINEY — When you receive an amount of money, presumably you put it in a high-interest account or some other interest-bearing mechanism to maximise the return, which would be treated as investment income. Would it not be reasonable to assume that AHPRA does the same thing? In terms of you raising the issues about investment that when a doctor pays a fee or any other medical practitioner pays a fee to be registered with AHPRA, the expenditure on that money would be done over the course of 12 months and that they would invest that money in some sort of trust account. That would be counted as investment income. So would it not be a reasonable explanation of the matters that you have raised?

Mr MILGATE — It could be. They would obviously get advice about the prudential management of funds. I do not think anybody is questioning that. I think the issue is, and we really do not have enough information here, are these reserves necessary? If you are a semi-retired doctor and you are paying your $680 a year, is this quantum of money required? If you are a nurse or midwife paying X registration fees, is this amount of money required? How much do they need to run the system, and is there an amount of money that is driving up these costs and allowing upward expansion?

Mr VINEY — Yes, I know. But what you put to us tonight is really raising a question as to whether or not AHPRA was somehow engaged — I took it that you were raising a question as to whether or not somehow AHPRA is engaged in some kind of investment strategy rather than looking after the interests of its registrants. I

am really raising the issue in terms of I would regard investing funds you know will be used and will be expended over the 12-month period to be wise decision making for any organisation. I guess the question is: have you asked AHPRA the question, given that you have raised this concern? Have you asked AHPRA to explain these funds?

Mr MILGATE — All we have done is refer to the accounts, an analysis — —

Mr VINEY — Have you raised it in a public hearing as a concern? I am asking whether you as an organisation have raised your concerns with AHPRA?

Mr MILGATE — No, we have not written to AHPRA and asked them about their investment strategy. No, we have not. We have just, for this inquiry, gone through these accounts. We are not at that stage.

Dr PRYTULA — Can I just perhaps make a comment, because I think that this is one of the things that we can slip into in thinking about AHPRA as if it is a company or as if it has shareholders? It does not. The doctors who are registrants in our case, for example, of medicine are not shareholders. They do not have a feedback system from AHPRA. AHPRA is a regulatory, disciplinary body and that is all. There is no other function that it serves for the doctors who are registrants. In other words, this is not a company that has to hedge against future possible downturns with investments, say. AHPRA has a captive audience of registrants, and it can raise the fees each year if it wants to.

Mr VINEY — Yes, that is true.

Dr PRYTULA — It is a very different system.

Mr VINEY — But it also has an obligation to manage the funds properly, and that includes investing those funds so that in future it might not have to charge the same registration fees at a level that it currently does. You are expressing concerns about the levels that it is charging. I am putting to you that there is an alternative explanation. I am simply asking whether your organisation — —

The CHAIR — Perhaps that is something we can ask AHPRA.

Mr VINEY — Hang on. I am putting to you that you have raised an issue — —

The CHAIR — Have you got a question, Mr Viney?

Mr VINEY — I am putting to you that you have raised an issue that questioned AHPRA and I am just asking whether or not you have sought an explanation from that organisation prior to bringing it here.

The CHAIR — Thank you.

Mr VINEY — I think that is a reasonable question to ask you in the context of whether there was a response.

The CHAIR — Mr Milgate has answered the question. I think we will move on. I think Mr Milgate did say that in the context of this inquiry they were going through that and had not contacted AHPRA. Is my understanding correct?

Mr MILGATE — That is correct. In preparation of this area, we brought in this element of having a look at the accounts just prior to this inquiry.

The CHAIR — One very last, very quick question.

Mr O'BRIEN — It is a key question, as I see it, for the terms of reference of our inquiry. Notwithstanding all the concerns you have raised in relation to the medical profession, and that may inferentially bear upon the subject matter of my question, the key term in our terms of reference is the protection of the public.

Mr MILGATE — Yes.

Mr O'BRIEN — We have the Queensland and other examples for that. Could you say to this committee, in terms of protection of the public, what are the benefits and/or disadvantages of the AHPRA that you are presently under and how does that compare to the protection afforded under the previous state-based scheme?

Mr MILGATE — We just made this comment, and we make it in our submission, that the more layers you have to go through — medical boards have always had the ability to suspend practitioners who they consider are dangerous. That resided with the Victorian medical board prior to AHPRA. That has always been a power of the minister exercised through the medical boards. You have a situation where you now have AHPRA handling complaints and they are sent on to committees. The more layers you have, the more possibility you have of misinterpretation.

Mr O'BRIEN — Underreporting?

Mr MILGATE — Yes. I can give you a case that came to my knowledge where a doctor was wrongly labelled as having an issue.

The CHAIR — Perhaps you could provide that information to the secretariat, if you wouldn't mind rather than — —

Mr O'BRIEN — Dr Prager, you touched on this in your presentation.

Dr PRAGER — Yes. I might refer you to my presentation. The viewpoint we have — the Australian Doctors' Fund — is that public safety has been impaired under this model compared to the previous model, because if you have doctors reluctant to get treatment if they are ill because of fear of being reported and they go on treating patients, how is anybody to know about it? It is much better to have the doctor on a voluntary basis seek treatment — get treated — at an early stage before danger occurs through a patient being treated by a doctor who is very ill.

Mr O'BRIEN — Given the time, if there could be further elaboration of that, particularly if there is a risk of underreporting if practitioners do not feel supported in their roles, and how this underreporting ultimately would compromise patient safety. I would also appreciate, just for convenience, the references to the budget papers, if you could send them into us — —

Mrs PEULICH — And that annual report — is that tabled somewhere? And what are the obligations of the board?

Mr MILGATE — This annual report is published on the AHPRA website, so — —

Mrs PEULICH — Yes, but is that it? Is their responsibility acquitted by uploading it?

Mr MILGATE — That is what we see as — yes.

Mrs PEULICH — To whom are they directly responsible?

The CHAIR — I think that was the question I asked earlier.

Mr MILGATE — To the joint committee of health ministers. That would be the nine health ministers eventually meeting as a group.

Mr O'BRIEN — Most helpful. Finally, also perhaps a further elaboration on the question Ms Hartland put and your disallowance point about the state regulatory system, because that is an interesting proposition to us.

Mr MILGATE — Yes. Happy to supply that information.

The CHAIR — Thank you. We appreciate those follow-up items you will be doing on behalf of committee. Can I again on behalf of the committee thank all four of you for being before us this evening and for providing your submission and your evidence. It has been most helpful. Thank you again.

Witnesses withdrew.