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

Participating members

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

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

Staff

Secretary: Mr R. Willis

Witnesses

Dr G. Davies, acting health services commissioner, and

Ms A. Palombo, legal and policy officer, Office of the Health Services Commissioner.

The CHAIR — Good evening. I welcome Dr Grant Davies, acting health services commissioner, and Ms Angela Palombo, legal and policy officer, from the Office of the Health Services Commissioner. Thank you for appearing this evening and for your written submission. 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. Again thank you very much for providing the submission you have.

I would like to now invite you to give a brief opening statement, if you wish, and then we will follow on with members' questions. Thank you very much.

Dr DAVIES — Thank you very much, and I would like to thank the committee for the opportunity to address it this evening. The first comment I would like to make is that the OHSC and AHPRA have an excellent working relationship, which is one of the best between a health complaints entity and AHPRA in the country. While there were some issues at the time of AHPRA's establishment, those appear, from our perspective, to have been resolved, and given the size and complexity of AHPRA as an organisation that is not particularly surprising in our view. A memorandum of understanding exists between all the health complaints commissioners except New South Wales and AHPRA, which is regularly reviewed and is currently under review by a small working group comprised of commissioners and AHPRA staff.

While the processes are quite good at the moment, the way in which AHPRA deals with notifiers in terms of the information they receive following an investigation is a source of some frustration to notifiers and can cause issues for us as well.

To the end of May this year AHPRA has discussed 549 matters with us. We have discussed a similar number with AHPRA. And we have formally referred 146 matters compared with 7 formally referred from AHPRA to us. Those figures are reasonably consistent with previous years.

One other matter is worth noting, and that is the issue of health programs for doctors and nurses. Given the significant investment in doctors' and nurses' education, support for practitioners who need that support is preferable. That is really all I would want to say at this stage, and thank you for the opportunity.

The CHAIR — Thank you very much for that statement and presentation. You just referred to the 549 matters that you have had discussions with AHPRA about. Are you saying that they have been dealt with in a timely manner? Are you satisfied with the time those decisions have been discussed and made in accordance with the health services commissioner?

Dr DAVIES — Yes, we are. On average it takes around four weeks, and it is unusual now for us to go beyond that time frame.

Mrs PETROVICH — Thank you for your submission. Some submissions to the inquiry have highlighted that there is an overlap in processes between AHPRA and the Office of the Health Service Commissioner and that causes confusion on some occasions for consumers and practitioners. Can you comment on those concerns that have been raised?

Dr DAVIES — I think it is true to say from OHSC's perspective that we have not been very successful in differentiating us from AHPRA. We are required by the national law to consult with AHPRA, and sometimes that results in people becoming confused about who is actually dealing with the matter, but certainly that is a focus of some discussion in my office at the moment.

Mrs PETROVICH — Obviously if there is that level of confusion between the two bodies, there is duplication. Do you say there is a waste of resources or a lack of timeliness perhaps?

Dr DAVIES — No, I would not call it duplication and confusion between the OHSC and AHPRA. I think there is a perception of confusion by consumers and possibly practitioners. I do not see that there is a duplication of services or duplication of effort, but certainly I can understand the difficulties for consumers around who is doing what.

Mrs PETROVICH — Have you got a suggested a way forward on that? How do we clear up that confusion?

Dr DAVIES — We have been looking at the way we correspond with complainants and making it clear that AHPRA does this particular piece of work and we do this particular piece of work. We are working on better ways to communicate that on our website and through our promotional materials.

Ms HARTLAND — In your submission you talk about problems with notifiers. Can you elaborate on that a bit more?

Dr DAVIES — Perhaps I can do that in terms of the way we deal with complaints.

Ms HARTLAND — That would be great.

Dr DAVIES — So a complaint comes to our office and we seek information from the provider and provide that information to the complainant. As a notifier they are not treated as being particularly entitled to any further information than the general public. In our complaints process they are an active participant; in the AHPRA processes they lose control, if you like, of the process. AHPRA will investigate and then only provide information that the general public would be entitled to.

Ms HARTLAND — Is that something that has been worked on, or it has not been able to be improved? It is just that I noticed in one of the submissions we have received that something a notifier had complained quite strongly about was not being kept informed.

Dr DAVIES — It is something that the health complaints commissioners have raised with Martin Fletcher. As I understand it, as part of that working party those sorts of issues are on the table for discussion.

Mrs PEULICH — Just a quick question. Do you think the system is working effectively? Where are the areas that require improvement?

Dr DAVIES — I think three years on from its establishment it is performing reasonably well from our perspective. Certainly we have regular and ongoing communication, particularly with me and the director of notifications, and we are quite responsive to looking at improvements in the way that we share information and deal with particular issues around delays and that sort of process. So yes, I think it is working reasonably well.

Mrs PEULICH — You would have heard the evidence given by the doctors' fund earlier. What is your view of their concerns about the lack of responsiveness of AHPRA in relation to certain business and responsibilities that it needs to undertake on behalf — —

Dr DAVIES — I probably need more specificity to answer that question.

The CHAIR — Would you like to clarify, Mrs Peulich?

Mrs PEULICH — No, I am just interested. You have said in your submission that you work quite effectively with AHPRA in responding to individual complaints, yet we have heard about the sluggish nature of the body that is overseen by nine ministers and to whom they do not appear to be directly accountable and that there seems to be no-one who takes specific lead responsibilities.

Dr DAVIES — I can only speak for the Victorian experience. My experience with the director of notifications in Victoria is that we work together very effectively. We are quite responsive and we do not have delays in Victoria.

Mr O'BRIEN — I had another question just to follow on from that. I was just reading your submission, and you say in the second part of the introduction:

> It is worth noting AHPRA is the administrative arm of a much bigger organisation. All the power vests with the national boards and is delegable by each of the national boards. This has meant that AHPRA institutes different processes for different national boards which has created some frustration about what AHPRA can and cannot do without reference to the board and —

I do not mean to be difficult but contrary to what you have just said to Mrs Peulich, but —

has led to delays.

Dr DAVIES — In the past, I should have said. It has led to delays in the past. We are not experiencing those delays now.

Mr O'BRIEN — What about the situation in Queensland? Are you aware of the situation with the handling and the banning of reports, the Hunter and Forrester reports? Does that raise significant questions as to, in a sense, the danger of a national model? Because if something has gone wrong in Queensland, that is one state. If it has gone wrong with the regulatory oversight in a national scheme, potentially it is going wrong across the country all at once without this interstate check — in a sense, a federal check. Do you have any views on that problem? First of all, what is your response to the Queensland situation — the key issue for protecting Victoria? And secondly, to that federalism check?

Dr DAVIES — My understanding is that the bill is before a legislative committee in Queensland. Our Health Services (Conciliation Review) Act has recently been reviewed. The discussion paper associated with that review did not canvass that model at all, and really that would be a matter for government, not for me, to comment on.

Mr O'BRIEN — Are you able to tell us whether or not Victorian boards are sufficiently supported by AHPRA, having regard to the events in Queensland, in relation to making timely decisions?

Dr DAVIES — Some comments made by members of the Health Services Review Council, which is a council that sits over the top of my office, were that they felt not as supported as they otherwise might be. Certainly I have raised that in this submission and I have raised it with AHPRA.

Mr O'BRIEN — Could you elaborate on the sort of levels of support they feel are lacking?

Dr DAVIES — It is a bit difficult second-hand. I did explore this at the time, but the member has moved to Ireland, so it is a bit hard to speak with him.

Mr O'BRIEN — I appreciate those difficulties.

Dr DAVIES — But he felt as though there was not sufficient support by AHPRA and through the chair in terms of education and quality improvement for him to successfully do that role. But that would be as about far as I would be able to take that commentary.

Mr O'BRIEN — All right. Again, going back to the protection of the public, particularly, say, in relation to serious criminal matters or where there is a need for urgent actions, there is potential for delays or cumbersome structures that have been identified — 1200 meetings was the first evidence we had — across the whole system. Are there accountability issues in terms of AHPRA and risks to the protection of the public?

Dr DAVIES — I am satisfied that if a serious risk to the public was identified in Victoria, AHPRA and we would work together quite quickly to address that issue.

Mr O'BRIEN — I draw you back to the Queensland situation because those at risk have been identified there.

Dr DAVIES — Yes.

Mr O'BRIEN — Are you satisfied that the risks that have been identified in Queensland have been properly investigated as to where they translate into the Victorian context, and therefore can you give an assurance to the public that the situation identified in Queensland will not arise here?

Dr DAVIES — Obviously I cannot say categorically that a similar situation would not arise, but on past experience with AHPRA in Victoria through the director of notifications and through the state manager, Richard Mullaly, I am satisfied that we have sufficient checks and balances in place to address those issues.

Mr O'BRIEN — Finally, what about the underreporting issue or the concern about doctors' own safety that was identified by Dr Prager in her recent evidence to us only half an hour ago on behalf of the doctors' fund? Are you aware of that concern?

Dr DAVIES — I am sorry; I was not here for that evidence.

Mr O'BRIEN — I am sorry; I thought you might have been in the room. She gave evidence that it was a problem with doctors in terms of self-diagnosis issues with these delayed procedures that could lead to a protection of the public problem, particularly for depression, suicide risks — obviously not only to the doctors but then to the public as well. I suppose it would be best if you had a look at the evidence rather than just hearing it from me. I do not want to verbal her evidence, but are there risks of underreporting of medical practitioner problems that could lead to safety issues for the public as far as you are aware?

Dr DAVIES — Not as far as I am aware, no.

The CHAIR — Dr Davies, you mentioned a few times that you are satisfied with the timeliness of the reporting. Can you just explain to the committee what the time frame is that you would think is reasonable?

Dr DAVIES — It is around four weeks at the moment on average, and that requires us to provide information to AHPRA for AHPRA to develop up a brief, provide it to the relevant board and get back to us in relation to what their view is about who is best placed to handle the matter.

The CHAIR — Prior to AHPRA setting up, would that be a similar time frame if you were dealing directly with a board?

Dr DAVIES — I would need to take that on notice. My understanding is that it was slightly less time, but I would need to check that.

The CHAIR — If you would not mind, thank you.

Mrs PEULICH — And is that a KPI for your office?

Dr DAVIES — I am certainly tracking how much time it is taking for us to get notification from AHPRA, but it is a bit difficult for us to use that as a KPI for our office when — —

Mrs PEULICH — Is that experience? Your anecdotal evidence is that it is reasonably timely. Is that captured in any sort of data or form of data that you would have?

Dr DAVIES — We are commencing gathering that information. We have gathered it in the past. Generally speaking it is not necessarily captured on a performance database per se but it is internal data that we are looking at.

The CHAIR — In your submission and in your presentation to us earlier you mentioned the doctors' and nurses' health programs. They are very significant programs, and my understanding is that the nurses' health program ceases on 1 July this year. You talked about the significance of those programs. Could you elaborate a little bit more about how you think they should be supported?

Dr DAVIES — I think because AHPRA is the regulator and manager of the system, having them manage a health program is very difficult. I am not sure whether if I was a registered practitioner who was having some health issues, I would want to go to a service that was funded by the person who I rely on for my livelihood. The registered practitioners have invested in them enormous amounts of money to practice. That seems to me to be an important aspect in supporting them. Part of the issue for me is also encouraging practitioners to seek help. There should not be impediments for practitioners to seek help, and having AHPRA run those programs may well be an impediment.

The CHAIR — Will you be concerned with those programs? I am referring to the nurse and midwife program, and the effect that will have in relation to those nurses and midwives — that is, that they will have nowhere to go — and the effect that might have on your office specifically in relation to complaints and the wellbeing of those nurses and midwives? Have you got concerns about that?

Dr DAVIES — Certainly concerns for the welfare of the nurses. Whether we get an increase in complaints will be a matter that we will need to track. Certainly if we get reports of practitioners of the nature that you are referring to, we would be discussing that with AHPRA and referring it to them.

Mr O'BRIEN — There would have to be a concern not only for the practitioners but also for public safety.

Dr DAVIES — Absolutely.

Mrs PEULICH — What are your KPIs?

Dr DAVIES — The number of complaints received, the time frame in which they have been resolved, how many matters were referred into conciliation and what sort of outcomes we received in relation to that. We are in the process of developing our annual report at the moment about what sort of issues we are receiving, how many issues relate to prisoners and how many issues relate to registered practitioners.

The CHAIR — Mr O'Brien has one final question in relation to your submission, Dr Davies, if you would not mind.

Mr O'BRIEN — In your submission it is noted that the notifier should receive more information of the decisions made on a practitioner's registration. Do you think there is also a risk to public safety due to a lack of information provided by AHPRA both to your office and to the public in those circumstances?

Dr DAVIES — We have certainly developed protocols in terms of information sharing. We do not necessarily see a risk in that. We get — —

Mr O'BRIEN — Sorry, would that be a risk that you are managing through those protocols?

Dr DAVIES — Yes, that is right.

Mr O'BRIEN — And you are comfortable at your end with your protocols?

Dr DAVIES — Yes.

Mr O'BRIEN — What about in relation to the AHPRA interaction with doctors at the other end before your office is involved?

Dr DAVIES — I am not sure I can comment on that. That would be a matter for AHPRA to deal with.

Mr O'BRIEN — Or the practitioners.

Dr DAVIES — Or the practitioners, yes.

The CHAIR — Thank you for that clarification. I do not believe there are any further questions, so on behalf of the committee I thank you both very much indeed for your presentation and your submission. Your evidence has been most helpful.

Committee adjourned.