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 — 9 August 2013

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Mr N. Elasmar	Mr D. O'Brien
Ms C. Hartland	Mrs I. Peulich
Mr A. Elsbury	Mr M. Viney

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Witnesses

Dr A. Atkins, vice-president, and

Mr D. Russell, Australian Society of Ophthalmologists

The CHAIR — I welcome Dr Andrew Atkins, the vice-president of the Australian Society of Ophthalmologists, and Mr David Russell, also from the Australian Society of Ophthalmologists. Thank you very much for being before us this morning and for the submission you have provided to the committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. All evidence is being recorded, and you will be provided with a proof version of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee website. I now invite you to make a brief statement in relation to your submission, which will be followed then by questions from committee members. Thank you again for being before us.

Dr ATKINS — Thank you. I am here in my capacity as the vice-president of the Australian Society of Ophthalmologists. We have 560 members and represent approximately three-quarters of all eye surgeons in Australia. As an education, there are two broad groups in Australia. There is the Royal Australian and New Zealand College of Ophthalmologists, which is the educational branch of our craft group, and then the more negotiating and political branch is the Australian Society of Ophthalmologists, and that is why I am here.

I have read a number of the other submissions to this hearing and a lot of them, especially the medical ones, focus on the preference for a return to a state-based control system of doctors for registration with retained portability of national registration, which seems sensible to us, and that was the thrust of our initial submission. We believe that AHPRA is quite cumbersome. We are surprised that the registration fees are more expensive, and we felt that the original system was working well. Historically we thought that the medical board of Victoria provided a good service for the registration of doctors and protection of patients.

Since our submission there has been a further development where there was a submission made to AHPRA by the OBA — the Optometric Board of Australia — and this submission related to a variation in practice guidelines. In fact, it specifically related to the use of medications in relation to the treatment of a condition called glaucoma. Glaucoma is a condition that affects quite a significant percentage of the population. It is an inherited condition that is treatable but can lead to blindness if it is not treated. The treatment is complex and may involve the use of drops, laser treatment or surgery, and it is a difficult condition to treat. Ophthalmologists, during their training, receive extensive training about the treatment of glaucoma, and the basis of the OBA submission was that they, optometrists, on the basis of a relatively short training experience, be allowed to diagnose and treat glaucoma without collaboration with ophthalmologists.

For many years ophthalmologists and optometrists have worked together to manage glaucoma, very successfully and collaboratively, and the view of the ophthalmologists or of the ASO is that we were happy for that situation to proceed. We felt, and we still feel, that unsupervised treatment of glaucoma by optometrists presents a risk for those optometrists who are inadequately trained. We think that the decision by AHPRA to allow this submission to go ahead represents substandard care of glaucoma in Australia.

So we made a submission, once the OBA made a submission, and with very poor consultation the submission by the OBA was approved. So their guidelines, which the OBA elected to change, were approved by AHPRA with little consultation and despite submissions from both the ASO and the Royal Australian and New Zealand College of Ophthalmologists. Subsequent to that there was a mediation meeting held. Do you know the date?

Mr RUSSELL — 23 July, I think, or 23 June. But we can check that for you.

Dr ATKINS — We can let you know who attended this meeting. It was held in Melbourne with the CEO of AHPRA. There were representatives from OBA, the Royal Australian and New Zealand College of Ophthalmology and the ASO, and also the chief medical officer from Canberra, Dr Chris Bagley, flew down, which is a measure of the importance that he considered the meeting to have. What we are trying to say is that when a craft group wants to vary its scope of practice, and that variation impacts or crosses over with another craft group, we think there should be better consultation. There was a problem with that process. We are so concerned about the result of the decision that we have since launched legal action. We have launched Supreme Court action in Queensland against the OBA, and all of this has evolved since we made our submission, and that is why I am telling you about this. We think it is very significant and we do need to provide you with more details about that legal case.

The CHAIR — Dr Atkins, we would be very pleased to receive further information that you have. I have just interrupted your statement. Would you like to make any further remarks before I move to committee members to ask questions of you?

Dr ATKINS — No, I think that is a good point at which to have questions asked.

The CHAIR — Mr Russell, would you like to add anything further before I go to that point?

Mr RUSSELL — Indeed. It goes back to the very foundation of AHPRA, which is for the regulation of health practitioners — not doctors, not medical specialists — and ultimately the original aim was to ameliorate cross-border registration issues. But all of a sudden when the AHPRA legislation came into the federal Parliament it gave AHPRA the power over accreditation of medical specialists, and this was done without any forethought or consultation and that is the nub of the major issue that we have here. When the Optometry Board of Australia gave itself, unilaterally, the right to diagnose and treat glaucoma, we felt that this was really very adversarial. We had the mediation process, and we received a very scant hearing from AHPRA.

We were left, then, with a choice. If someone goes to their optometrist and is diagnosed or misdiagnosed with glaucoma, this was the legal advice we received: they could wander off, and it might take a year or two for the difficulties to emerge; then if they found that they had been misdiagnosed or were suffering or going blind, they would have to take legal action against the optometrist, which would have to be resolved. In the case of four or five years you might have a resolution on which ophthalmologists might then be able to take action against the OBA. We said this was simply inadequate for patient safety and wellbeing.

We had to seek a judicial review, which we have done in the Supreme Court of Queensland with OBA as the respondent. This is a very difficult issue and it has become very complex. They have questioned the standing of ASO and RANZCO, which in itself is quite remarkable since RANZCO sets the standards for ophthalmology in Australia. To say that RANZCO does not have standing before the courts is drawing a very long bow. We now have the situation that a delaying tactic has pushed our potential hearing date before Christmas back to the new year, and again patient safety is being jeopardised, potentially, all around Australia while this situation pertains. Again, the situation was that when OBA gave itself the authority to unilaterally diagnose and treat glaucoma it was done without expert clinical oversight.

This is the great flaw within the AHPRA legislation. The Australian Medical Council sits there, but we do not believe its opinion was sought on this particular decision, and this is at the heart of the legal action that we have taken.

The CHAIR — Thank you very much for that. For the benefit of the committee, could you just briefly explain the incidence of glaucoma? I know that in certain communities there are much higher rates of it — for instance, in our Indigenous communities. I do not know if you have specific rates for Victoria, which we are particularly interested in. My point is that the issues you raise will not be touching one or two individuals but quite a number of people are potentially at risk here. Am I correct in my assumption?

Dr ATKINS — Can we take that question on notice and give you the precise details? The percentage of people who are blinded by glaucoma is relatively low; the percentage who are diagnosed with glaucoma in the ageing population would be, let us say, around 15 per cent. That is the sort of incidence; I may not be precise. I should have brought the precise figures with me. I apologise for that.

The CHAIR — That is all right. I am just trying to get a handle on the numbers in relation to the potential of patients to be affected by the decision that you have described.

Dr ATKINS — The concern was that there was an inadequate ability of ophthalmologists to meet the demand for care of this condition and therefore that optometrists help diagnose and manage the condition. As I said before, we are very happy to manage this condition in conjunction with optometrists. I have a lot of friends who are optometrists, and for many years we have collaboratively managed glaucoma. Between the two craft groups there are more than enough people to diagnose and manage this condition, but we believe that it is safer for best practice care to have ophthalmologists involved in the treatment.

The CHAIR — Certainly. Could you also clarify for me whether it was the OBA's submission to AHPRA that recommended this line of treatment?

Dr ATKINS — Correct.

The CHAIR — When did that occur? When was that submission put in?

Dr ATKINS — They put in the submission in November.

The CHAIR — 2012?

Dr ATKINS — Yes, at the end of last year.

The CHAIR — And when was their decision finalised?

Mr RUSSELL — March 2013.

Dr ATKINS — Yes. We heard about it and put in a submission in approximately February, as did the college of ophthalmologists, and without any meeting or adequate consultation process the decision was made to ratify the decision by the Optometry Board of Australia.

Ms HARTLAND — Can I take that one step back again. You were not informed that this was occurring? There was no notification to your organisation, but you heard it from other people, and that is what made you put in the submission?

Dr ATKINS — I think the OBA's submission is a matter of public record. I am not sure that we were directly notified, but we found out at some point. I do not think that we were actually asked to make a submission, but we did.

Mr RUSSELL — This is the standard modus operandi of AHPRA, that, frankly, everybody is treated with disdain. They take the view, from their legislation, that: they publish something on their website; it is a matter of record, and people, if they should know, are supposed to find this out themselves. We were not notified, and I do not believe any of the particular stakeholder groups were involved in this. When OBA or any of the other 14 national boards reach their decisions on potential extensions of scope of practice, they simply publish their results on the website, and it becomes law. That is it; bang. All that has to happen is that it be published on the website, subject to having been consulted on widely. The term 'widely' is in very great variance.

The difficulty is that it is not just the Optometry Board of Australia. This extension of scope of practice allowing allied health professionals to encroach on the territory of medical specialists and physicians is happening across the board. AHPRA is involved in a similar situation with psychologists, as against psychiatrists; midwives; and podiatrists and orthopaedic surgeons. For instance, my understanding is that podiatrists have approval to operate on the foot, and it is now chasing up to the knee, which was always the orthopaedic surgeons' thing. They have now applied for approval to prescribe scheduled medicines in case anything goes wrong with the operation on the foot that needs rectification via medicines. This is where the whole practice of medicine is being slowly undermined by an organisation that was originally supposed to look after only cross-border registrations — and now takes in upwards of $120 million a year to do this.

The Australian Society of Ophthalmologists says that we should revert to a state system because when we had a state-administered system of health and medicine in Australia we had world best practice medicine in Australia, and that is being eroded.

Ms HARTLAND — In talking about the state boards, I cannot bring forward a case now but I was aware that under that system there was also often criticism about the way the state boards operated, especially in regard to doctors or psychiatrists or psychologists who were actually practising outside their regime and the fact that it would take an extreme amount of time to deal with that. You do not believe that there has been any change. What I am trying to get at is that it seems that there were a lot of faults with the previous state boards as well, and clearly there are problems with AHPRA, but is reverting back to the state boards actually going to fix that? We could end up in the same situation; they will just be local.

Dr ATKINS — With regard to state boards, there have been problems with state boards, and there have been highlighted legal cases, particularly in Victoria in recent times. There was one particular case where perhaps the medical board should have acted much more aggressively, and they did not. Obviously we need to respect that fact of history. With the current system there seem to be many more layers between the health

minister and the doctor. I think we need a state health minister to know and be responsible for the doctors who work in their state. I notice that Queensland and New South Wales have moved in that direction, but I also noticed in a recent media release from AHPRA that that may result in incurring extra costs, which to me does not seem to make sense. That is purely with regard to registration of doctors and protection of patients, which is such an important function of regulatory authorities.

Our other issue, which has evolved since the submission, is variation of scope of practice of craft groups, where there is overlap between craft groups and that inadequate consultation process.

Mr O'BRIEN — I would like to take up just a couple of questions, following from that more recent issue in relation to the overlap between craft groups. The example you gave is a neat example for our purposes of raising regulatory issues. Forgive me; I am not trying to insult your profession or anything, but the tension in any regulatory environment will be between what some would say is opening up what is an area of expertise that you have to a broader body of people. That might be said to be done because of medical advances. I think that the Fred Hollows innovation was to do with glaucoma; am I right, or was it cataracts?

Dr ATKINS — He was more involved with cataracts.

Mr O'BRIEN — Thank you. Forgive me. It is just so that I can understand. I think Ms Crozier started this, that there is an argument that there is a percentage of the population that is not being reached under the current rules, if you like, and then you have this tension between the two bodies. We are not going to resolve that tension, but in terms of the process issues for us considering the regulatory environment, what would you recommend as a means of allowing society to, in a sense, have a regulatory environment that can allow extensions or innovations where appropriate, if that is desired, and also protect important protections where they need that supervisory role?

Dr ATKINS — That is a very good point, and there have been evolutions in the treatment of glaucoma. They are not quite so spectacular as the evolution of treatment for cataracts, but there has been the development of new drops, which are very effective, new surgical techniques and laser. We are very happy to work with optometrists to explain and interact with them about the treatment of glaucoma with the new drops. We are very happy to do that and always have been, because it makes it more efficient for managing the condition — that is, apart from laser and surgery, which are obviously more advanced.

Mr O'BRIEN — Sorry, I just want your answer to focus on the facts. I know it is hard to take us outside the facts, but what process does your board have? Do you envisage receiving submissions from each side of the debate, in a sense, and the public having a say? How do you propose — —

Dr ATKINS — What we would concentrate on is a consultation process prior to a decision being made. We really need to ask the question, 'Is this best practice?'. We need to compare what we have got with what is being proposed during the consultation process, and we need to consider evidence during that period. We did not have the opportunity to do that. That is the regulatory sort of thing that we would like to see happen.

Mr O'BRIEN — Thank you; that is helpful. If I could just turn to another aspect of your submission, thank you for providing your recommendations. They are quite discrete but, in a sense, powerful from your point of view. It is all about the Victorian government resuming direct responsibility for registration and regulation. Could elaborate on that but particularly draw the committee's attention to some of these financial issues? You say the expenses amount to $129 million and that AHPRA managed to lose more than $6 million in the period. It might be a fairly lengthy answer, but we would appreciate it.

Mr RUSSELL — It is intriguing that in the three years they now employ 700 staff across Australia to manage the sector, and in three years they are now reaping in excess of $120 million a year for no appreciable net gain. Australia had a first-class medical, hospital and health system before. It has not been improved. We now have 700 more public servants, and it is $129 million out of pocket. They reported a loss of $6 million in the last financial year, and one has to wonder why or how. All of a sudden in the same period of time they have an asset base of $82 million reported in their annual accounts. As a layperson — and I have no financial expertise — that just seems quite strange to me.

Mr O'BRIEN — Moving to your capacity as a representative of the society, what financial transparency has your organisation sought, and what have you been provided with by AHPRA — that is, the breakdown of the money?

Mr RUSSELL — While we find AHPRA's budgeting to be of note, we are not overly concerned with the finances. Our concern is that if you bring it back to optometry and ophthalmology, you have a system where advances in technology enable health practitioners to expand the scope of practice to an extent. Smarter chips, smarter lasers and all of that give people in a particular field an edge. What we are talking about with glaucoma is the diagnosis of disease, and that is a medical specialty; it is a doctor's prerogative, and AHPRA is enabling all sorts of health professionals, not doctors, to expand the scope of practice without expert and clinical oversight into areas that are not the domain of physicians. This is a dreadful danger to the Australian public.

The CHAIR — Can I interrupt you and ask: in relation to AHPRA taking on responsibility, are they able to do that through the national legislation?

Mr RUSSELL — Absolutely.

Dr ATKINS — It was originally legislated as an authority for the registration of health-care professionals. This gave autonomy to the boards. There are 14 different medical groups, and they have autonomy under AHPRA. That is what the OBA was entitled to do, or allowed to do, as a result of the new legislation, and we have a problem with that.

The CHAIR — Yes, thank you — sorry, Mr O'Brien?

Mr O'BRIEN — No, I think you have answered the bulk of the questions, particularly with the concerns about the protection of the public. The ultimate terms of reference of this inquiry are the Victorian public, how it is best protected and obviously your views on that. You mention one other aspect in your third dot point. You say:

> AHPRA's standard bearers make much of the notion of accountability yet the very structure of the oversight … undermines it in practical terms. The fact that it reports to nine health ministers across the nation effectively means that the buck stops nowhere. The previous situation in which state and territory ministers exercised direct supervision proved itself to be sufficiently rigorous.

Could you expand on that point? If you look at it from a national infectious disease or population control point of view, previously you had eight or nine state systems. If there was a problem in a state system, it could be quarantined, in a sense, to that state system whilst others perhaps did it better; the same with innovations. In the national system, if there is a problem at the national level, it can spread across the lot. Is that a concern that you are identifying? At the same time there is no specific accountability, because currently we still in theory have those state controls as well.

Mr RUSSELL — Yes, indeed, and I think this comes to Ms Hartland's drive towards accountability. Where you have nine health ministers sitting together as a collective, okay, you get a great overview, but as the doctor earlier alluded to, it is incredibly difficult to get anything onto that council of health ministers' agenda. We spoke to the Queensland health minister and were told that we could not get anything, that they would not get over even their existing issues for the next seven or eight months, let alone raise a new issue and get that onto the agenda of the council of health ministers. That effectively means, as that submission says, that really the buck stops nowhere. In the earlier days, when you had state-based administrations, at least the Victorian minister took responsibility for what was happening in that patch.

The CHAIR — Just to clarify that point, you are saying that with those nine ministers sitting around a table, effectively nobody is taking responsibility for these issues or decisions?

Mr RUSSELL — It is very easy in a collective for responsibility to be so shared as to become meaningless.

The CHAIR — Mrs Peulich has just joined us.

Mrs PEULICH — Apologies, but I certainly get the gist of what you are saying. Perhaps they hold hands and sing *Kumbaya* at some point in time, but I think the message is resonating through.

Mr RUSSELL — You might say that, but I could not possibly agree.

Mr O'BRIEN — It is another matter on which if you could elaborate further in writing it would be great. You put up an alternative to current arrangements and say that:

> … refinement of the previous system could be achieved through creation of a central advisory board, comprising state and territory chairs.

Then you talk about a collaborative basis. What role would you see left for AHPRA or a national body, in a sense, if you are reverting back to the states in that? I just want to be quite specific as to where a cooperative federalism, as it is called, as opposed to a national uniform scheme, would work out.

Dr ATKINS — It is helpful to have a national registration system. That is beneficial, but what we want are efficient lines of communication on a state-based system.

Mr O'BRIEN — I am sorry. That last answer conflicts with your first recommendation, which is that:

> The Victorian government utilises all available avenues to resume direct responsibility for the registration and regulation of all medical practitioners in that state.

Dr ATKINS — Let me rephrase that. I said that there are benefits in having a portable qualification, a portable registration, so that a doctor registered in Victoria can work in New South Wales or Tasmania, and the state-based system was effectively moving towards that anyway. So we would prefer state control of the medical fraternity for better protection of the patient. That is all we are saying.

Mr O'BRIEN — So the guts of it is that in your example you would have had the state ophthalmologists and the state optometrists having that debate, and it would be quarantined at least initially to Victoria?

Dr ATKINS — At state level, yes.

Mr O'BRIEN — At state level in the guts of it, but then you would have a coordinating role so that all the boards are talking to each other at a federal level?

Dr ATKINS — Correct; which is what we used to have, effectively. Yes, that is a better summary.

Mr O'BRIEN — Thank you for that.

The CHAIR — I do not believe that there are any further questions, so can I on behalf of the committee thank you both very much indeed for attending this morning. We do appreciate your time, and your evidence has been most helpful.

Mr RUSSELL — We thank you for the hearing.

Witnesses withdrew.