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 J. Buntine, president, Australian Association of Surgeons.

The CHAIR — I welcome Mr John Buntine, president of the Australian Association of Surgeons. Thank you very much for appearing before the committee this afternoon. 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 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 statement to members of the committee in relation to your submission and the evidence you are going to provide to us, and following that presentation I will open up to questions from the committee. Thank you very much for being before us, Mr Buntine.

Mr BUNTINE — Thank you very much for inviting me. I am very pleased to attend, because AHPRA is something I have taken a considerable interest in for three reasons. Firstly, I was the vice-president of AMA Victoria over 10 years ago. At that time, the AMA was trying very hard to achieve a simple, flexible and inexpensive scheme for the national registration of doctors. A lot of effort was put into that, not successfully. Secondly, as president of the Australian Association of Surgeons I became concerned about what was happening in Queensland, especially with respect to Dr Jayant Patel. Thirdly, Dr Joanna Flynn was the chair of the medical board of Victoria before she became chair of the Medical Board of Australia.

This update produced by the Australian medical board has just been released. It is actually dated June, but it was received only a short time ago, and in this Dr Flynn firstly points out that AHPRA has now existed for three years. The update explains that the Queensland health minister has recently appointed a health ombudsman to handle all serious complaints about health practitioners, and that means that AHPRA and the Medical Board of Queensland are completely bypassed when there is a complaint — it is called a notification these days — about a practitioner. As an explanation for this, I will read Dr Flynn's exact words:

> This is in response to his view that the current arrangements have not worked effectively to protect the Queensland public.

I will read it again:

> This is in response to the view that the current arrangements —

that is, in Queensland —

> have not worked effectively to protect the Queensland public.

But we still have exactly the same arrangements in Victoria that have not been changed, and as far as I can determine, the only difference in Victoria is that the staff of the medical board of Victoria and of AHPRA locally actually get on much better at a personal level. Dr Flynn points out that at the time the AHPRA scheme was being negotiated the New South Wales government set up a somewhat similar co-regulatory arrangement between the New South Wales Health Care Complaints Commission and AHPRA.

In Victoria we had a better health services commissioner arrangement than that which existed in New South Wales, and that was very well known. Beth Wilson is an extremely competent person. But in Victoria, although much of it was modelled in Victoria, for some reason that was not included in the arrangements.

In Western Australia, one modification was made at the time of negotiation of AHPRA, and that was that a doctor is not there required to make a mandatory report about a doctor-patient. When I was here last, Dr Shirley Prager explained the importance of this. One of the main problems I see with the AHPRA scheme is that at each level AHPRA holds on to the funds and the staff — it is always held at the higher level and there are multiple levels — and the result is that the state medical boards, which are the bodies that do all of the real work with respect to complaints and notifications, are actually starved of facilities and funds. They are having a difficult time financially with respect to that.

It surprises me that people do not appreciate how hard it is to find a doctor who thinks that AHPRA is a good scheme. I do not know why people do not talk more openly about it; between ourselves there is a lot of talk. Mostly doctors are just pleased that AHPRA is functioning as well as it is. They thought it was going to be an absolute disaster. In truth and fact it is functioning reasonably well.

What do I think can be done better? There are those who would like to see the whole AHPRA scheme completely destroyed, but I think it has gone too far for that. It would be much better for everyone if the complaints went directly to the medical board of Victoria. Presently they go to AHPRA. But if you are wanting

to complain about a doctor, what is AHPRA? If they have to go to AHPRA, it should at least be renamed; it should be the National Health Registration Authority or something like that. Why keep a name like that for a person who has to look it up on the web to make a complaint? That is one thing.

The Western Australian modification about mandatory reporting should be adopted by all the states. One of the problems with AHPRA is that the state ministers and the federal minister are all on equal footing; they all have to get together to make an agreement to change anything. Mandatory notification is such an obvious one; I think all health ministers could agree to that. I think most changes that could be done should be done administratively. The main one that occurs to me is the transfer of the functioning of staff from AHPRA to the Medical Board of Australia. It does not matter so much where they are paid and so forth. That would make the whole system work a lot more easily.

There are a lot of issues. This is a very helpful AHPRA document, *A Guide for Practitioners — Notifications in the National Scheme*. From our point of view the association submitted something to this inquiry for today and also when it was first mooted in January of this year. Those documents are available.

Other things that concern us — and I will not talk about them now, but I would be pleased to speak about them if asked — include task substitution and the cost to practitioners of registration. I could also talk at length about how I feel about COAG, but I expect that it is not relevant at this time.

The CHAIR — Thank you very much indeed for that presentation, Mr Buntine. I am going to go to the issue you raised in your opening statement, which was the Queensland health minister's support of a Queensland health ombudsman. You also said that AHPRA is functioning reasonably well. My question is: if it is functioning reasonably well, why is Queensland breaking away from the national scheme and having its own regulatory body to oversee complaints?

Mr BUNTINE — The one matter that I know about in Queensland was that AHPRA would not pass on complaints about doctors without substantially investigating them first. That is the way the scheme is supposed to work. A slight distortion of that is happening in Victoria, for the benefit of the public. The situation in Queensland was that AHPRA used to hold on to complaints. The president of the medical board used to have to contact AHPRA and say, 'Look, if there is some suspicion that a doctor's doing things really badly, you've just got to let us know straightaway'.

The CHAIR — You said that there is a distortion in Victoria. Does that potentially put the public at risk?

Mr BUNTINE — The situation in Victoria is that there are nice people in both schemes who get on well, but I do not think that something like this should be dependent upon people forming good relationships with each other. There should be a process. The process is wrong; it is just that people in Victoria are making a bad process work well, whereas in Queensland people are making a bad process work badly. I do not know a great deal about what is happening in other states. New South Wales were aware of problems like this from the start and they did not get involved in this scheme; they have their own arrangements for dealing with complaints about doctors, which sound rather complicated to me. The schemes I know about are Queensland and here.

The CHAIR — Thank you.

Ms MIKAKOS — In terms of this informal arrangement that you said is based on relationships, this is information between AHPRA and the medical board — am I correct? Have I understood you correctly?

Mr BUNTINE — Yes. My information is that in Victoria at the present time AHPRA is passing on information very appropriately, but it is still a strange situation. It really ought to be the medical board that is employing the investigators. They should not have another group employing the investigators and getting the information second-hand. It is still not encouraged for the medical board to have a direct relationship with investigators. The investigators should be investigators of the medical board, not investigators of AHPRA.

I understand that the idea raised previously was that consumers felt that if it was a doctors organisation then they were not going to get a fair go but that if it was a government-type organisation then they would — —

Mrs PEULICH — If it were a government organisation, no-one was going to get a fair go.

Mr BUNTINE — Yes, I understand that, but nevertheless there is a tremendous inefficiency in doing it that way. Perhaps the right thing would be for AHPRA to have specific, appointed members to the other national boards that actually report back and tell consumers directly that they do not have anything to do with doctors, they are with the national scheme, or something like that.

Mrs PEULICH — We are hearing some recurrent themes in relation to the present system. My concern is that at the very top of that system — the COAG group of ministers responsible for AHPRA — there is not a single person who has the responsibility for making the decision, which in many ways creates a sluggishness throughout the organisation. We know that the further away decision making is from the grassroots of the notifier's experience the more difficult and torturous that process may be. Just to get it clear in our minds, are you advocating a hybrid model or are you being more robust than that?

Mr BUNTINE — Yes. I think there is some advantage in the hybrid model, but I think the medical board of Victoria has been put too far down the decision-making process. Related to that, I believe that the Victorian health minister ought to have a formal relationship with the medical board. I know that was a problem in Queensland because the health minister there complained about some matter and he was just told, 'You've got no right. You don't have anything to do with this. This is a national scheme. What are you talking about?'. Therefore he then scrapped the whole lot.

Mrs PEULICH — Bureaucracy wins. Thank you.

Mr ELSBURY — I am sorry; I missed the beginning of your presentation when you may have canvassed what I am about to ask. In relation to the length of time it takes for AHPRA to undertake an investigation, what has been the experience of your members? What would you see as being a reasonable time frame?

Mr BUNTINE — I think that is a hard question to answer, and in situations like this it is also hard to give reasonably hard facts. I do know that in Queensland it was much too long, but I am not aware of it taking any exceptional time in Victoria at the present time. But what I am aware of is that in some instances of complaints about doctors it seems to be some time before the doctor hears anything about it at all. People live in a bit of an uneasy situation; they do not know whether there has been some complaint about them or whether there has not.

That is described in this nice document that I sat here. It actually points out that in some situations they may not wish to notify the doctor; they may have some specific reason they want to do the investigation first, and I can understand that. But I do not think that is the majority of cases, because so many of the cases have got to do just simply with the doctor being rude or making some quite understandable mistake — because medicine is pretty complicated and all people can do is their best, and they do make mistakes. It is only if the mistakes are made too frequently to be acceptable that there should be a problem.

The CHAIR — Thank you.

Mr ELSBURY — During an investigation what has been the experience of some of your members, then, because you have just said that sometimes they do not know they are being investigated? How have they found the AHPRA organisation when it comes to ask them about a case?

Mr BUNTINE — Again I cannot give any specifics. But naturally it is very uncomfortable for doctors to be investigated about things like this, and therefore it is very hard to make judgements as to what is reasonable and what is not reasonable. Initially when AHPRA came in there was a lot of trouble. For instance, in New South Wales there was a doctor who was working in partnership with an older doctor, and the older doctor just did not like them and invented stories about how poor their treatment was. What happened there was that the doctor who was innocent, as far as one could tell, had their registration immediately suspended, and that meant they could not get any Medicare payments. Eventually it was found that it was jealousy and that sort of thing that was responsible.

I know of that, and that was written up a fair bit, but I do not know of any situations like that in Victoria. In Victoria things seem to be going pretty well, but the same structures exist. I think it is just because of Joanna Flynn's influence in here and that there is a different understanding that things are working all right at the present time, but it is just not a good structure and it only takes different people to be involved and we will see the same sorts of problems as we see in Queensland.

The CHAIR — Thank you.

Mr O'BRIEN — Thank you, Mr Buntine. Just in relation to those risks could you identify, as best you can, in relation to regulatory inefficiencies with the AHPRA system to what extent they may actually increase risks to the Victorian public, or to the Australian public if it is a national problem?

Mr BUNTINE — I cannot give an estimate of something like that.

Mr O'BRIEN — Could you identify any particular ones you are concerned about in relation to regulatory inefficiencies?

Mr BUNTINE — There is no specific matter that I would want to refer to here. There is one matter that I did not mention, and that is the matter of task substitution. This is an effect of AHPRA because the other boards have the rights to decide what their practitioners will do. There is a very specific problem going on at the present time whereby the optometry board wishes its members to have the rights to treat glaucoma without any consultation with an ophthalmologist and so forth. So that is the sort of thing — —

The CHAIR — We actually received evidence from the society of ophthalmologists this morning.

Mr BUNTINE — I think that is serious, actually.

Mr O'BRIEN — Do you have a view not on the specifics of who should treat glaucoma but on the process by which those sorts of field disputes should be resolved?

Mr BUNTINE — No, in that instance I have a very specific issue about who should treat glaucoma, because I think that with glaucoma the essential decisions are best made by an ophthalmologist, but it should be a shared treatment with the optometrists. You know what I mean; we are almost getting into situations like homebirthing. The doctors are the people who have the very broad education. Optometrists do not learn anything about the rest of the body and the effect of drugs on it and all that sort of thing. That is specific, but still the specific brings out the general, and the general is that it is not right for each individual — like, for instance, in surgery the podiatry board may decide that podiatrists can do knee replacements or something like that. That might sound silly, but things like that happen in the United States. There are lots of these side issues at AHPRA that we really have a lot of concern about.

Mr O'BRIEN — Just discussing then, again — and I will specifically ask a quick question on the ophthalmologists' position, because they came before us and I think they espoused a similar viewpoint to yours on the glaucoma issue — that they believe they can engage in a consultative process with ophthalmologists, provided there was a supervisory role et cetera. But as I understand it the process complaint is that the board of the ophthalmologists effectively made that decision and then AHPRA has ratified it without giving the ophthalmologists an opportunity to be heard on consultation. Are you aware of that instance and what happened in that instance?

Mr BUNTINE — Yes.

Mr O'BRIEN — Could you comment on the process that took place and what you think should — —

Mr BUNTINE — It struck me as being different to what I expected. When all the registrations were put into the one group I thought that therefore there would be some direct relationship between the boards, say, of optometry and medicine. And that is the sort of thing that did happen in the past. But then the AHPRA scheme decided that the fundamental idea is that everyone is of equal value and therefore everyone should be able to be independent. These are just ideas which I think are philosophically perhaps acceptable but in practice are misleading.

Mr O'BRIEN — I have one last question on that, if I could. Just in terms of protection of the public, and you have identified the Queensland situation with — well, it is public — Jayant Patel and those issues, if there is a regulatory problem like what you say may happen with glaucoma, under the present national system, if that is approved across the country in a singular move, in a sense exposing the whole country's patients to it. Whereas one benefit of the previous system, the state-based system, that has been identified to our committee was that if there was a problem in Queensland it was in a sense confined to Queensland from a regulatory point

of view and therefore the protection of the public. Is that something you would identify as a systemic problem with the way the national regulatory model is being rolled out?

Mr BUNTINE — Yes, it can happen with podiatry — in each field, you can think of something like that happening. I think what underlies it is — it is the COAG problem — that there is no-one really in charge. There is no single health minister who gets the boot if they make a mess of it. It would be different if it was a federal scheme; then the federal health minister would be responsible. But the federal health minister is no more responsible than the minister of Tasmania. It is just a bad system. I mean, it is a bureaucratic system; it is not a system of which I approve.

The CHAIR — So in effect nobody has responsibility?

Mr BUNTINE — Nobody has; the buck stops nowhere.

Mrs PEULICH — Pass the parcel, is it?

Mr BUNTINE — It just stops with a group of health ministers.

Mr O'BRIEN — And just going back to Victoria, previously the buck stopped with the Victorian health minister, and in more practical terms the various medical boards regulated their professions in a way. How did you consider that system worked?

Mr BUNTINE — Yes, I think that is sound. The type of medical registration that we would have wanted was like a drivers licence system, whereby if you were registered in one state you could act in another state and the problems came back to the state you were registered in. But there would have needed to be a little bit more in the way of complexity and so forth. But a lot of the troubles could have been done away with by just having a decent computer system whereby you could look up a doctor irrespective of which state they were registered in, and so forth. To lump all these independent specialties together just makes it less safe and does not give any administrative advantage at all.

Mr O'BRIEN — Could you briefly comment on one aspect of the evidence we have heard that has intrigued me. It has also been said that a problem of the national system is that you now only have to be registered once across the country and that that does not necessarily provide a good practical check on doctors moving from jurisdiction to jurisdiction, because there might be a problem. Although there might previously have been some inefficiencies in moving from state to state, that at least provided some protection to the public when someone asked the obvious question, 'Why are you moving from Brisbane?'. Are you aware of any issues in relation to that?

Mr BUNTINE — I am not aware of any issues, but I think it is a good point — although the other system also had some problems. A state that could not easily attract doctors used to be a bit easier to register in. Doctors who used to register in that state would move somewhere else. For all these things there are advantages and disadvantages. These days computers should be able to pick up things like that. If a doctor is moving all over the place, the computer ought to be able to just spit out something preset as to where this chap or girl is practising.

The CHAIR — You would think so. There are many advances in technology, but there is still a way to go on this issue. I do not believe there are any further questions from committee members. Mr Buntine, on behalf of the committee thank you very much indeed for your evidence this afternoon. It has been most helpful.

Mr BUNTINE — Thank you very much for listening to me. I was rather expecting to have a harder time than that.

The CHAIR — You have done very well.

Committee adjourned.