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 — 17 April 2013

Members

Ms G. Crozier	Mr D. O'Brien
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Mr P. Allen, Chair, Agency Management Committee,

Mr M. Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency

Mr R. Mullaly, State Manager (Vic), Australian Health Practitioner Regulation Agency;

Dr J. Flynn, Chair, Medical Board of Australia; and

Mr S. Marty, Chair, Pharmacy Board of Australia.

The CHAIR — Good evening, gentlemen and Dr Flynn. 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 representatives from the Australian Health Practitioner Regulation Agency and relevant boards: Mr Peter Allen, chair of the Agency Management Committee, Mr Martin Fletcher, chief executive officer of AHPRA, Mr Richard Mullaly, state manager for Victoria of AHPRA, Dr Joanna Flynn, chair of the Medical Board of Australia, and Mr Steve Marty, chair of the Pharmacy Board of Australia.

I caution you that 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. 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 would like to thank you for your submissions and your preparedness to appear at this time of day at Parliament. It is greatly appreciated. I now invite you to make a presentation to the committee, after which we will have questions.

Mr ALLEN — Thank you, Chair. Can I extend my congratulations to you in your new role. The interesting aspect to me is that at least in respect of your gambling responsibilities you have joined the esteemed rank of regulators; that is a nice touch.

I want to make a few brief points before handing over to AHPRA CEO Martin Fletcher and then Dr Flynn, chair of the Medical Board of Australia. Our comments aim to reinforce some of the key points in our written submission. As you are aware, the decision to establish the national system of health profession regulation was a decision of the Council of Australian Governments. The national scheme exists because all governments of Australia determined that it was a sensible reform in the national interest.

In response to the many and varied submissions, governments also determined that the scheme would be a partnership between the professional boards appointed by health ministers and the administrative arm of the national scheme oversighted by the Agency Management Committee, which I chair. The committee was also appointed by health ministers from across Australia.

The progress and success of the scheme to date I think reflects very well on the health ministers' appointments to the national boards and the responsiveness of AHPRA staff. Health ministers, including Victoria's health minister, both funded and oversighted the establishment of the scheme and continue to provide policy direction and oversight of the scheme and its performance. Consistent with this responsibility, health ministers will be conducting their own review of the scheme's first three years of operation later this year.

There are two other comments I want to make by way of introduction. As chair of the Agency Management Committee, I am more than aware of both the start-up challenges that face the scheme and the requirement that we continue to identify and address opportunities to improve the service we deliver to consumers of health services, to registered health practitioners and to the educators who train them. In addition it is important to note that regulators and health system leaders around the world are watching the progress of this significant international reform with both admiration and interest.

Finally, I want to share with you a story that I think highlights one of the key benefits of the national scheme. In early 2009 I was working for the Victorian health department. At about 7 o'clock on a Friday evening my phone rang. It was the commanding officer of the Australian Army unit that had arrived in Victoria with two doctors to help treat victims of the Victorian bushfires. He wanted to know how he could register these two doctors as quickly as possible consistent with the regulatory environment that then existed.

As it happened, the then registrar of the Medical Board of Victoria, Richard Mullaly, who is with us tonight, was also about to leave his workplace at 7 o'clock that Friday night and was able to open it the office, and due to the fact the army doctors had all their paperwork with them was able to expedite their registration so they could immediately deliver much-needed medical care.

As a government official at the time I asked myself what Victorians would say if the media headlines the following morning had read 'Red tape delays doctors treating bushfire victims'. One of the many achievements of the national scheme is that this could no longer happen in Australia. I will now ask Martin Fletcher to give you a bit more detail about the scheme as it presently operates.

Mr FLETCHER — I am going to just step through the presentation of which you have a copy and give you a brief overview of how the national registration and accreditation scheme works in Victoria. For ease of shorthand I will call it the national scheme. In doing so I will highlight some of the key elements of the AHPRA submission and also try to respond to some of the other points that have been made in the other submissions that have been received by the committee. To reinforce Peter's message, we welcome feedback from stakeholders and partners and the opportunity to look at how we can continue to improve what we do on behalf of the Victorian community.

Overheads shown.

Mr FLETCHER — The headline of our submission is essentially that overall the national scheme is working effectively in Victoria. In our submission we seek to draw on a range of data to demonstrate why we think that is the case. We make the point that the national scheme largely builds on previous Victorian regulatory arrangements, so there are a lot of elements of the national law that reflect much of what was very good practice in the prior arrangements in Victoria, and then in some areas the bar has been raised. For example, in the national scheme we now have mandatory checking of criminal history when applications for registration are made. That was not a feature of the Victorian legislation prior to the national scheme.

As Peter said, national registration means that practitioners can register once, pay once and can practice Australia-wide in the context of the scope of their registration. We estimate that around 22 000 Victorian health practitioners alone have benefited from that and are no longer required to have multiple registrations. They held registrations in more than one state or territory prior to the national scheme.

This gives you some of the headline data in terms of the work of the national scheme in Victoria. There are around 153 000 registered health practitioners in Victoria, and the growth during 2012 has been around 6 per cent, so there is no evidence that we can see that any elements of the national scheme are in any way limiting the growth of the health workforce. In fact we now have 28 000 registered students in Victoria across all of the 14 professions in the national scheme. Previously in Victoria we only had student registration for medicine. We now have it for all of the professions in the scheme, so that is an added public protection. And around 21 per cent of the notifications, which is what we call concerns or complaints about health practitioners, occur in Victoria. What we are seeing, particularly in our data this year, is the beginnings of an upward trend in terms of the rate of notifications that we are receiving, not just in Victoria but in other states and territories as well.

While much of the focus and what is known about the work of the national scheme is about the registration of health practitioners and dealing with notifications of concerns, there are three other important arms of our work. We work very closely with and provide support to national boards in their very important role of setting standards for the professions in terms of requirements and registration. We have a big program of working with what we call 'compliance', which is essentially both auditing the requirements of registration with practitioners and monitoring those practitioners who might have conditions associated with their registration. We also have a role in overseeing the standards which educational programs must meet to become approved programs of study as the pathway for registration, largely through a set of arrangements with independent accreditation authorities and national boards in particular.

This slide reminds you of the professions that are in the scheme. In the first column are the 10 professions that came into the scheme on 1 July 2010. These were professions that were registered in every jurisdiction in Australia at that time. The column on the right includes professions that came in from 1 July 2012. They were not registered in every jurisdiction, so here in Victoria the registration of Aboriginal and Torres Strait Islander health practitioners and occupational therapists is new. Chinese medicine, which has been regulated here, is now recognised and registered nationally, so that has been an example of where Victoria has actually led nationally.

This slide gives you the screen shot of how many registered practitioners there are in Australia, with the Victorian column highlighted. I literally produced this, or somebody produced it for me, at the push of a button today. The point is that you simply would not have been able to produce this data prior to the national scheme. The inconsistencies and differences in how data were collected across the states and territories meant we were unable to say how many registered health practitioners we had in each of the professions. This highlights one of the other benefits of the national registration: producing much more accessible, accurate and nationally consistent data, which is obviously then very important in terms of workforce planning and policy.

One of the major features of the national scheme in terms of public protection and transparency is the fact that for every one of those 588 000 registered health practitioners we publish online information about their registration status, and this is easily available to the committee through a single website. Again, prior to the national scheme not all professions in Victoria published online registers.

I have taken the liberty of printing out Dr Joanna Flynn's register entry just to give you an example of what you would see in the register, and then you can go in for more details. As you can see, Dr Flynn is registered as a medical practitioner with a specialty, and her specialty is in general practice. If there were any conditions associated with her practice — for example, there might be requirements in terms of her registration or conditions associated with some form of disciplinary action taken by board — then this would also be published on the national register. The only exception to that would be if it was a health-related condition. We also separately publish a list of practitioners who have had their registrations cancelled by a tribunal or court, along with a searchable database of the decisions. Those are very important public protections arising from the national scheme.

Peter has touched upon this issue of the scope, scale and ambition of the change that ministers had in terms of establishing the national scheme and the fact that we are unique internationally both in terms of our national focus and our multiprofessional focus. There is a lot of international interest in what we are doing. I was particularly interested in the submissions you have received. The one from the UK Health and Care Professions Council, which in a sense is a fellow multiprofession regulator, described a 10-year journey in terms of the work they had done to create their scheme there as well as some of the significant investment they had to make at the start of their scheme. It is important to note that that particular effort in the UK does not include the complexity of nursing, medicine, dental or pharmacy, all of which are separately regulated in the UK.

I will briefly turn to some of the issues raised in some of the submissions. We picked up a theme of clarity about the mechanisms for accountability and local accountability and the understanding of the roles and responsibilities within the national scheme. As has been mentioned, we have a ministerial council which has oversight responsibilities in relation to the scheme. That brings together all of the state and territory health ministers along with the commonwealth health minister.

Among other things they appoint to national boards and they approve the registration standards that boards develop — that is, the standards for registration. The minister in Victoria makes appointments to any of the state boards that exist in this state, and then of course there is a wider accountability — for example, we have an independent health practitioner ombudsman for the scheme who has particular roles in relation to oversight of our processes for dealing with our business and privacy and FOI issues. Of course we have the continued role of bodies such as VCAT in terms of dealing with issues such as decisions to cancel registration.

National boards have the primary regulatory decision-making role in the scheme. National boards set the standards, policies and guidelines, and then it is state boards and committees that deal with individual registration and notification matters. AHPRA administers the national scheme, working very much in partnership with the boards. We have a local presence in every state and territory. We have a state office in Victoria, which is led by Richard Mullaly, and the bulk of our work for the Victorian community is done here in Victoria through that state office.

A second theme that came out in the submissions were the concerns that have been expressed about fees and fee increases following the commencement of the national scheme. Fees are set by national boards, and it is right to say in some cases they have increased significantly as a result of the national scheme. There is a single national registration fee for each profession, and that fee must meet the full costs of regulating that profession within the national scheme because there can be no cross-subsidisation between professions. For example, one of the things that those fees need to do is actually meet the costs of some of the new obligations in the national scheme.

I mentioned before the requirement for compulsory criminal history checks. We did 60 000 of those in the past year, which cost close to $2 million. As I mentioned, we have student registration. There is no fee for students to be registered. All those costs must be met by each of the boards. Of course boards also fund in most cases the accreditation arrangements. In a number of cases that has seen the withdrawal of previous government subsidies for those accreditation arrangements and the full cost of that is being met by national boards. The boards very much have to set fees with no expectation of any government subsidy. The other important issue for boards and

fees is maintaining adequate reserves to be able to manage cases and mitigate risk, particularly in terms of case costs associated with notifications.

We also recognise very much the importance of transparency. Boards are very conscious of the legitimate interest of the professions in understanding how fees are spent and what they are used for. As you would be aware through our annual report, we are externally audited by VAGO on an annual basis, and we have to provide an annual report, which is tabled in each Parliament around Australia. We have moved to provide quite detailed information in that annual report, broken down by profession, of how fees are used and what they are spent on. We also have a thing called a health profession agreement, which is a formal agreement between the board and AHPRA for fees, work programs and budgets on an annual basis, and we also publish those health professions' agreements on our website.

I will briefly go to the management of notifications, which again is another theme that came out of the submissions. We have a national system for managing notifications, and these are about the conduct, performance or health of health practitioners. We have a slightly different arrangement in New South Wales, but have a very close working arrangement and any of the decisions that occur in New South Wales appear on the national register. One of the things we highlighted in our submission is the value of the national sharing of information in terms of making sure that issues do not fall between the cracks. The law has given us some good flexibility in how we deal with notifications, and again that has built on and mirrored many aspects of what was in place previously in Victoria. Of course we now have mandatory reporting, which is not new for medicine in Victoria but is certainly new for other professions. It means that there are requirements in terms of when concerns must be raised with a board.

Finally, the issue of consistency and clarity of communication came out as a very important theme in the submissions. The feedback suggests a number of areas where we need to continue to improve in terms of the information we provide to practitioners. We do have a local customer service team in Victoria, so Victorian practitioners and the community are dealing with a local team that is based here in the state. I looked at the data for last week and it dealt with over 3000 phone calls alone last week from a range of practitioners and members of the community. We have developed a service charter which sets out clearly what people can expect in terms of service they receive from AHPRA.

We are establishing a community reference group for the national scheme, and in fact we had a number of community forums last year, including here in Melbourne, to get involvement and engagement with that. Boards themselves do a lot of direct communication. There are now regular electronic newsletters that go out from boards to practitioners. We are about to publish something we are calling *A Plain English Guide to Notifications*, which will address the importance of the practitioner being subject to a notification, and having clear information about what they can expect in terms of the process of how that will be handled.

My final slide picks up on some areas where there may well be opportunities for improvement, which may be of interest to the committee. We have certainly said in our submission that in terms of the area of notifications there is more we can do to make sure that good information and feedback comes to notifiers. There are partly a set of issues around how the law is currently constructed, but there are also things we can do administratively to make sure notifiers are aware of the progress of a matter where they have expressed a concern. We have a very good relationship with the health services commissioner and that works well, but we want to continue to strengthen that relationship and make sure that is as streamlined as it possibly can be. It is probably reasonable to expect that we develop and over time are able to publish benchmarks and performance indicators in terms of what people can reasonably expect might be the time frame for dealing with a notification.

Secondly, I think there is a set of issues around liaison with employers. One thing that would be useful is perhaps to establish a local health services forum in addition to the liaison we have with individual employers. We also are looking at developing an electronic data exchange from our national register so that an employer could get a bulk download of information, and if there was a change in the registration status of one of their employees or a set of conditions on their registration, they would know that. We are currently trialling that. In fact Epworth is one of the hospitals that is trialling that with us.

Thirdly, there is this issue of communication with the public and practitioners. I think there are opportunities for us to continue to review and strengthen our service charter, and probably to do more to formalise our consultation locally, with consumer groups in particular, to make sure that we are getting good feedback and

input into where there are areas that are still unclear or uncertain for members of the community. I will stop there and hand over to Dr Flynn.

Dr FLYNN — I want to make a few comments about what the changes have meant for practitioners and for the boards. Firstly, as Martin Fletcher said, the fact that somebody can register once and practise anywhere in Australia is enormously important in terms of cross-border practice, telemedicine, radiology and pathology services and people who want to be itinerant health professionals working in different places and have a reasonably flexible lifestyle.

On boards, we now have a process where we know that anybody who is registered in any profession around Australia is registered by a consistent set of standards. I have been involved in medical regulation for a long time. While the state-based boards used to meet a couple of times a year and talk about what standards they were setting for English language or other entry to the profession, they would all go back and go on doing what they had been doing. Now we have had to come to an agreed position around what are the appropriate standards, those standards have been signed off by the ministerial council, and it is clear to everybody what the standards are and that they are uniform around the country.

The board has already published a code of conduct for all doctors in Australia and the other health professions have published codes for their professions. The medical board has done a lot of work on the issue of doctors' health programs, and that was an issue that was raised in the submissions. There was a health program funded here in Victoria under the old scheme. The funding was continued for a three-year period. The national board took some time to try and make sure we were very clear about what is the role of the regulator in monitoring and managing practitioners who have an impairment versus what is the role of a health program to support and facilitate re-entry to work of people who are fit to return to work and early intervention. Now that we have got that clear, we have announced that we intend to fund health programs around Australia on a continuing basis. Again, as we are getting to a more steady state operation, we believe we are able to do that without any specific increase in registration fees to fund that.

There are some other ways in which being in a multi-profession scheme is very helpful. There are many issues where the standards across professions ought to be consistent. For instance, we have fairly consistent standards around English language. We are developing common standards around the use of social media. We have got common provisions and guidelines around advertising. There are a lot of things that happen synergistically. It is easy for people to find out what the standards are, because they are all on the same series of linked websites.

One of the big advantages for medicine in the national law is the whole way in which we deal with overseas-trained medical practitioners and international medical graduates. As I said, we now have common standards, but we are also able to deal with a lot of the duplicative processes that existed before in registration because, as a national body, the board can deal directly with the Australian Medical Council, the accrediting body, and with all of the specialist colleges, which are national colleges, and keep better track of what is happening. We have just undergone a process of developing some new streamlined pathways which are out for consultation and which we think will be significantly effective in making it clearer to international practitioners what they need to do to get registered and make it quicker and easier for them to get registered, provided they meet the appropriate standards.

The fact that this can all be done once and done in a way that there are very good processes in the scheme to allow consultation so boards cannot go into a closed room and make up their minds about what they are going to do by themselves. We need to have formalised consultation processes, but once we have done that we can introduce the same set of standards to be implemented around the country, and we can provide information on one website where people can understand what the standards are.

As Martin Fletcher said, it has been a complex transition process. There are still some things which are only now getting to maturity in terms of process. I have been involved in international medical regulation forums and, for instance, the Canadians are absolutely astounded that we have been able to bring this off across eight jurisdictions, let alone across a number of professions at the same time.

I think there are a lot of opportunities here. The medical board has read the submissions carefully, and there are some issues there that people are still concerned about. Some of those are historical, and we have not really communicated effectively enough with people about what we have done to address them, but I think the scheme

is well placed. In fact there are few things that achieve one of their stated aims on the first day that they come into law, which is to create national registration and which this scheme has done.

The CHAIR — Thank you very much for that thorough presentation. Perhaps I will start with the first question. Mr Fletcher, could you expand on the point of notifications? You talked about the increase in notifications that you are seeing, and you mentioned in passing mandatory reporting. I wonder if you could flesh that out a bit more. Do you have an understanding as to why you are seeing increased notifications?

Mr FLETCHER — Yes, of course. As I said in my presentation, around 21 per cent of the notifications that we receive about health practitioners occur in Victoria. I think I said Victoria represents about 26 per cent of the national total, so it is a little bit less than the proportion of practitioners. What we are seeing in our data, particularly this year, is an upward trend. Overall at the end of March we are 75 per cent through the year, and our notification rate is about 81 or 82 per cent of what it was last year. It is not consistent across all professions, and it is not consistent in all states and territories, but it is upward here in Victoria.

Some of the reasons that may be occurring is because there is greater awareness of the national scheme. I think it reflects the fact — and Dr Flynn may want to come in on this — that when you look internationally, on the whole most regulators are experiencing an upward trend in complaints, so I think it may well also reflect those international trends.

In terms of mandatory notifications, if you go right back to why we have mandatory notifications, I think the question there was a sense that in the past when there were concerns about practitioners it would come to a crisis point and people would say, 'Yes, I knew about that for a long time', and nothing had happened. Mandatory notification is about making very clear the circumstances in which people are required to advise of a concern about a practitioner. In the national law that applies to a health practitioner, it applies to an employer and, in some circumstances, for students it applies to an education provider as well. We are looking very closely at the data on mandatory notifications, and we report that as a separate category in our annual report. We are particularly wanting to make sure what we are seeing in that category of notifications.

I think it is fair to say there has been some need to clarify what the threshold is for mandatory notifications, so one of the things we have also put a big emphasis on is helping people understand what the national law says in terms of the requirement as opposed to what some of the perceptions and fears might be about the circumstances in which they are required to notify.

The CHAIR — Thank you for that answer. I will ask one other question before I pass over to Ms Hartland. Dr Flynn, you spoke about the doctors' health program being funded on an ongoing basis and, Mr Fletcher, you talked about some of the feedback the committee has received in relation to fee increases. Do you anticipate now that fee increases going forward will be closer to the cost of CPI-type increases? Do you think those significant fee increases now are behind you?

Mr FLETCHER — The vast majority of boards, particularly those that came in in 2010, have made a commitment. Unless there was a significant change in terms of their functions and responsibilities, they would expect that their fee increases would stay within the national CPI threshold.

I think for the four new professions that have come in it is still early days. It is probably too early to say in relation to those professions, but certainly for the 10 professions that came in 2010 unless there is a major change there would not be an expectation of an increase above CPI.

Ms HARTLAND — I am particularly interested in the upcoming three-year national review. Could you take us through how that review will occur and what things will be looked at?

Mr FLETCHER — Not really, because it is not our review. It will be a decision of the ministerial council what the terms of reference for that review are, and they are yet to announce those terms of reference.

Ms HARTLAND — And when will that occur?

Mr FLETCHER — Just to give you the background, the intergovernmental agreement that was originally signed by the Prime Minister, the premiers and chief ministers at the time talked about a review not before three years of the commencement of the scheme, so the earliest that it could occur would be 1 July this year. In terms

of the commencement of that, it will really be subject to the ministerial council meeting and determining the terms of reference and then how they wish to conduct the review.

Ms HARTLAND — The reason I ask is that this was an issue that came up very early on when this reference was being discussed — whether this was an appropriate way to review it and whether it was actually necessary. I presumed that somewhere along the line the work would be reviewed by another body, and it would seem that we may end up having a parallel review along with this committee. That is why I asked the question.

Ms CROZIER — Thank you very much for your submission and your presentation tonight. I would like to take you back. Dr Flynn, you mentioned the doctors' national health program, and in your submission you also talk about the Victorian nurses and midwives' health program. I would like to take you to that part of your submission which says:

> When the national scheme came into effect on 1 July 2010, funds were set aside by the Nurses Board of Victoria for the continuation of the NMHPV until 1 July 2013. The NMHPV is managed independently of the national board. The national board has, however provided additional funding of $500 000 for 2013–2014.

In your presentation you said that you were funding the doctors' program on an ongoing basis, is that correct?

Dr FLYNN — That is correct.

Ms CROZIER — Could you explain to the committee if this funding for nurses and midwives ceases after 2014, or is it a similar ongoing program?

Dr FLYNN — The medical board has made a decision about future funding of health programs for medical practitioners. The nurses board, as I understand it, has made its own decision, which at the moment is to not continue funding.

Ms CROZIER — After 2014 for those programs, is that correct?

Mr FLETCHER — That is correct. There was the three years funding that was, in effect, ring-fenced with the reserves that were transferred into the national scheme. The board in addition to that has agreed to further funding for the financial year 2013–14, so the funding would cease on 1 July 2014.

Ms CROZIER — I am just wondering, because this has been a concern for nurses and midwives, who have created a number of petitions in relation to this particular issue, why the medical board has taken that step to allow that program to continue or to fund that program, which obviously I understand is important to doctors as well. Could you give us some background as to why they have taken that decision?

Dr FLYNN — I cannot comment on why the nurses and midwives board has made the decision that it has.

Ms CROZIER — I understand that, but from your perspective, from the doctors' perspective, why have you taken the decision to continue with that program?

Dr FLYNN — There are a number of ways to answer that question. Our role is to promote professional standards, ensure professional standards and facilitate access to health services; they are the broad roles in the act. We believe that having a healthy workforce that is well supported is a good way of doing that.

The medical board believes, and has sufficient evidence to show, that doctors often make very poor patients. They do not access health care in the same way as ordinary people do. I do not mean by that that doctors are extraordinary, but sometimes we believe we are. In our code of conduct we say that all doctors should have their own general practitioner and they should seek appropriate health care when they need it, but we know that there are many people who do not do that. They wait until they are too sick, they find it difficult and they wonder if they can find a doctor who will understand their special needs.

We believe that rather than having a confrontation with them about it and saying, 'Just go and behave like a normal grown-up person', it is better to create a system where they know that they can call somebody and get some help over the phone, and they can get directed to practitioners where we have evidence that they are willing to treat other doctors and will do that appropriately. That is one thing: early intervention, education of

medical students and promotion of doctors' health. We have a good record of success in the programs that we have.

There are particular risks for medical practitioners in relation to health issues, particularly because they can prescribe and access drugs in ways that many of the other health practitioners cannot. In our view it is worth doing. We have not fully worked through exactly what sort of model we will deliver around the country and what sorts of evaluation frameworks we will have on that, but we believe it is an important commitment to make.

Ms CROZIER — If I may, I will ask either Mr Fletcher or Mr Allen: do you believe that a similar program should be provided for nurses and midwives? Do you have any comment on that? It has been an ongoing concern for that particular profession, for similar reasons, I would surmise, to the doctors. I am interested why the medical board sees fit to support the doctors in an ongoing fashion. Under the old scheme those programs were funded and provided for both nurses and midwives, and doctors. Could you please comment in relation to that?

Mr ALLEN — If I can I will make a couple of comments, firstly to reinforce the reality that it is a decision of the nurses board of Australia. The second issue is that the program was provided distinctively in Victoria, so a decision at the national board level becomes an interesting one in terms of whether you use national fees to continue to provide a service for only one jurisdiction or whether you look at providing a service that was not previously provided in any of the other jurisdictions by levying an additional charge on registrants.

I think, as Jo has highlighted, these are issues that need to be talked through by the boards. It is a live issue with the nursing board; they have not made a conclusive decision as far as I know. Their preference is not to do it at present, but there is obviously pressure on them from those who believe it is a sensible continuation of a program. It does raise a whole lot of issues which would potentially impose additional costs on registrants. At the same time all health professionals are very mindful of not adding additional cost to the scheme which translates into additional fees for registrants.

Dr FLYNN — Perhaps I can add to that, Ms Crozier, in terms of the medical board's thinking. It became much easier for us to make a decision to fund programs nationally when it became clear that we could do it within our existing fee structure without having to add additional fees. I am not sure that that is clear yet for the nursing board in terms of its financial scheme. Medical registration fees are now $680 a year, which is a lot more than the nursing fees.

Ms CROZIER — What are the nursing fees?

Mr FLETCHER — Nursing fees are $160 per annum.

Dr FLYNN — Our estimate is that it would be of the order of $20 to $25 per medical practitioner to run the sort of health program that we are talking about around the country which, again, within the funding that we are talking about becomes feasible. But it would be a question for the nursing and midwifery board of whether that would be feasible for them.

Mr FLETCHER — If I could perhaps add, just to conclude, I think in some ways the issue of budget has been less of an issue for the board than the fact that the board, having been asked to consider the future of the program, did some work to look at what support there was to roll out a program nationally, and the conclusion of that work was that there was not support for a health program nationally and there was not necessarily support for the Victorian model of the health program nationally. As we have indicated, their decision has been not to continue funding the current program at this stage beyond the end of the next financial year.

Mrs PETROVICH — Thank you for your presentation tonight. Do you see an increase in notifications of complaints in Victoria as an increase in poor performance? What is the process for dealing with those notifications?

Mr MULLALY — I do not believe that it is an indication of an increase in poor performance. I think, as we have suggested before, the public are a lot more aware, consumers are being encouraged to be aware of what they can do in the regulatory sphere and the scheme itself has got a marginally higher profile that might not be well known to many. But certainly mandatory notification and aspects of the national law such as that mean that

even practitioners when they hear about things are saying, 'That does not sound right. Here are the people to contact'.

Every time a call is made to the Victorian office and the word 'complaint' or 'notification' is used — there are a variety of different terms used — it is sent directly to a triaging area where we have got three full-time, experienced staff who can commence the conversation around that. Under the national law we need to confirm that it is in fact a notification. There are several steps. It has to be about a registered practitioner and there is a variety of other aspects. Whether in fact it is a notification can be concluded very quickly.

At that stage we commence getting an amount of information together and every notification goes in front of the board for an assessment by a notifications assessments committee. Every board has one of those. Medicine meets more regularly than others — once a week — and others meet once a fortnight or once a month depending on the number of practitioners and what the board has decided to do. It is a board decision as to whether the notification is taken any further. That is usually put into an investigation where there is a more fulsome understanding of what the circumstances were. The practitioner is invited to provide a response and the notifier is invited to provide a response. The board then satisfies itself by going to other places, getting evidence from other areas, getting expert opinion, and so on, and an investigation is done. Then the material is handed back to the board and the board then decides as to whether there is going to be an outcome or not.

Under the national scheme, in comparison to what we had prior to that even in Victoria, there is a capacity for the boards to make quicker decisions without committing to a hearing or a tribunal. Cautions and conditions can be placed on a practitioner if the board decides it is necessary. That can occur in a quicker manner compared to what that was before. Those are the general terms of how those notifications go. We provide the administrative support and the advice to the boards so that they can make an informed decision.

Mr FLETCHER — Just to add to what Richard said, I think in circumstances where there is a question of a potential immediate risk to public safety we have a provision for immediate action under the national law, so if necessary a board can move within hours to review a complaint that has been made and decide what appropriate action might be taken. That might include some sorts of conditions placed on that practitioner's registration, some sort of undertaking from that practitioner about limiting what they do until there is a more complete investigation or, in extreme circumstances, it can include the suspension of a health practitioner. There are quite strong steps that can be taken where there are questions of immediate public safety.

The other point to make, and I think this is one of the things that we try to communicate, is that the focus of the national scheme and boards is on public protection. The national law is very clear that the role of looking at notification is really to understand what the potential risk might be to the public and to take the minimum steps required in terms of any restrictions that might need to be placed on that practitioner to assure the safety of the public and then over time to make sure that whatever those concerns are, they are addressed. It might be requirements for additional supervision or additional education and training to address whatever the concern is. We are not fundamentally a complaints resolution agency, we are really about a protective jurisdiction, and I think that is why our interface with the health services commissioner is so important, because obviously their role is much more focused on complaints resolution.

Mrs PETROVICH — Further to that, can you talk about how the committee is comprised, how the committee is appointed? I do have an area of interest in whether there is natural justice also for the health practitioner in that process.

Mr FLETCHER — Do you want to give Victorian examples, Richard, of medicine?

Mr MULLALY — In Victoria, the size of the profession tends to generally determine how often these notification and assessment committees or notification committees meet. Their formation is determined by the national board in circumstances relating to medicine and the nurses. They are subcommittees, if you like, and the national board says who is going to be on them. Medicine is a good example. There are two notification assessment committees each of six; there are four practitioners and two community members on each. They cannot meet unless there is a community member available. If the matter is going into investigation, then the results of that investigation are assessed by a performance and professional standards committee of similar makeup. The board itself is ministerial appointments of eight practitioners in medicine and four of community members. In nursing it is six practitioner members and three community members.

In the smaller professions the national board will appoint a notifications and registration committee. This might be four, five or six practitioners who meet virtually and consider all the matters in a four-week cycle right around the country. If it is podiatrists, for example, there are not too many notification matters relating to podiatrists; but when there are they are assessed by that committee by the same mechanism — the notifications assessment committee and the performance and professional standards committee — and the matter is assessed by them on that cycle. The makeup again is practitioners and community members in a set two-thirds to one-third makeup.

Mr O'BRIEN — Thank you for your attendance and your submissions. I think COAG support et cetera demonstrates that in theory a national registration scheme model is perhaps a good idea or a universally accepted idea. The problems we have received, and certainly those the federal inquiry revealed, relate to the implementation of that idea. We have had very strong evidence, for example, from the Victorian health department that there are now 1200 meetings a year across the various boards. You might have seen that transcript. I think it was described as a 'multi-headed hydra'.

What is difficult for us as a committee is to break down where we were and where we have got to now. I note your submission acknowledges that as a direct consequence of the scope and pace of the reforms there were some early challenges in the implementation of the scheme that affected Victorian practitioners. I think you have received or you are aware of the AMA's very strong views at the time of the Senate inquiry, which were to say that it:

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

In sorting out the various complaints we can go through some questions. It may be very difficult for us to get a meaningful fix on where problems are in a sense historic or have been worked on by AHPRA and the various boards and where those problems still remain and particularly what solutions need to be put in place to fix that goal of protecting the public, and also perhaps alleviating some of the bureaucratic problems that doctors face.

I was going to ask you a general question, but if I could just ask you about some specific complaints by way of example. We have the AMA's letter here which on page 2 says:

> It reflects poorly on the operation of AHPRA that doctors have been required to fix what are errors induced by AHPRA itself. The medical profession should not have to spend their time in this manner which must necessarily affect patient services.
>
> Doctors have also commonly reported that the process for communicating with AHPRA staff is arduous and overly time consuming.

Do you accept that sort of criticism? Probably Mr Fletcher could answer initially, but I am happy for others to answer in relation to the AMA's submission.

Mr FLETCHER — Perhaps I could make a couple of comments.

Mr O'BRIEN — Yes, I accept that was a big preamble.

Mr FLETCHER — You have made reference to the Senate submission, which is now two years ago, and I think we acknowledged in our submission to that inquiry that there certainly was a set of issues around the start-up of the national scheme to do with the scale and scope of the change that occurred where we essentially turned off on one day a set of state-based arrangements and moved on the next day to a whole new national system.

Our view, certainly as we have tried to reflect very strongly on an empirical basis, so we have **tried** to provide data and not just assertions, is that the fundamentals of the national scheme here in Victoria are very sound and that the foundations of the national scheme are very strong. That is not to say that we think it is perfect and that is not to say that we do not think there are areas that need to be improved. Clearly one of the themes, as I picked up in my presentation, is that we need to continue to make sure that the customer experience, if you like, of dealing with AHPRA in terms of getting questions answered and getting clear information and that occurring in a streamlined way is something we continue to pay very close attention to.

I think we have made enormous gains in that area, and that is recognised in many of the submissions. I believe from my reading that people recognise that there was a period of start-up issues. A lot of them have been

addressed, and now this is really about how we make sure that the scheme is the best it can be, particularly, as I said, that the customer experience, as a practitioner, is as smooth as it can be as well.

Mr O'BRIEN — That is where we need to get to as a committee to be able to sort through what still remains outstanding, particularly whether there are any structural deficiencies, at least from a Victorian point of view, that we can recommend changes for. I am also concerned as to the problems in rural areas, such as in my electorate with the overseas doctor issue, which can be a problem of not enough in there and at other times it can be supervision issues. I understand the role of the bureaucracy is very important there, and the registration for the protection, and there is a submission, for example, that we need much more tailored, localised solutions. I could ask you to answer that specifically, but there is one more general question that I would like to ask you that would assist us, if I could.

We have received a lot of submissions, and you have received them also. Through you, Chair, would you be able, if we were either to direct you or to ask you politely, and I am happy to do it in the way you have set out your submission, to go through each of those submissions to identify where you accept that the criticisms that have been made are valid but have now been worked on in this way so that we can identify the issues that remain to be fixed. When you say there were communication problems and registration problems, it is very general language and it is very hard for us to sort out if you are right when you say it has been fixed or they are right. If I was to ask if you would be able to do that, do you think you would be able to do that?

The CHAIR — Mr O'Brien, I think it would be better for you to put a proposition to the witnesses and seek their response. It is unreasonable to ask them to provide a critique of each submission.

Mr VINEY — Correct. It is a lot of work.

Mr O'BRIEN — I am just asking if they can do that, because in a sense they are the body — —

Mr VINEY — That is the job of the committee.

Mr O'BRIEN — It will be the job of the committee to assess whether there is still dispute.

Ms HARTLAND — And the parallel review that is going on.

The CHAIR — Mr O'Brien, if you could put a specific question about a particular issue to the witnesses, and then I will attempt to — —

Mr O'BRIEN — Am I permitted to ask if they are prepared to respond to the criticisms that they see in the submissions?

Mr VINEY — I think that is an inappropriate question. Can I just say that, first of all, it would require a resolution of this committee to determine whether or not it was seeking such information from this organisation. It is not a question for one member of the committee. I do not think that one member of this committee is able to ask another organisation to go away and do work. That is a decision of the committee, not a decision of a member.

Mr O'BRIEN — There is a difference between a direction and an answer to a question. My question was whether they were prepared to do it. That is my question, and if there are directions that need to be made, then that is a matter for the committee. But my question is very simple: are they prepared to respond to those criticisms that have been made on the public record in a more detailed and specific way?

Mr ALLEN — I think we have a responsibility, certainly from an agency management committee point of view, to establish the clearest possible understanding of how the scheme is working at present and how people access it. So if we can provide additional information to the committee that assists you to form a view that historical problems have been addressed and the sorts of issues that were part of the first few months of the scheme's operation are no longer the case, then if we can provide that information, we will do so.

I should also probably highlight that in the organisation's work every day Martin and his team are making decisions about prioritising various tasks. Inquiries like this are obviously an important part of our accountability mechanism, but there is an opportunity cost to them. We are also mindful that later this year we will be gearing up for the national review and that will require a significant investment of executive time to

ensure we are able to provide appropriate support to that review. But obviously the parliaments and the governments that are the joint sponsors of this scheme are a critical part of our accountability mechanism, so we will always prioritise that work if it is framed in a way that we can respond to.

Mr VINEY — Firstly, thank you for your presentation. Secondly, my apologies for being a few minutes late; I was double booked for meetings, so I went to one and apologised and then came here. I want to follow up on the issues raised by Ms Hartland and just referred to by yourself, and I want some clarity. I think you said, Mr Fletcher, that the review was not to occur before three years — not sooner than three years, I think, were your words. Is that correct?

Mr FLETCHER — The IGA talks about not before the first three years of the scheme. Effectively 1 July this year would be the earliest.

Mr VINEY — That was my next question. Just to confirm that is 1 July. Was that a decision of the ministerial council or in legislation? Where is that determination?

Mr FLETCHER — It is in the intergovernmental agreement that was signed by the then Prime Minister, premiers and chief ministers.

Mr VINEY — So it was part of the ministerial council decision-making process?

Mr FLETCHER — No, the intergovernmental agreement. COAG essentially.

Mr VINEY — Effectively this review is actually happening six to eight months ahead of that not before three years position. Thank you very much.

Ms HARTLAND — Can I just follow up on that? Presumably the current health minister is aware that this review is about to occur, because he would have had to have been involved in it.

The CHAIR — I do not think it is appropriate for a question like that to be asked.

Ms HARTLAND — No. I am asking it because I think it is an appropriate question. This is a reference sent to us from the health minister at the time the issue was raised about whether there were any parallel reviews happening. I am trying to ascertain whether the minister would have known that this review was to occur at the same time that he insisted on this reference to this committee.

The CHAIR — Ms Hartland, that is a matter we can perhaps consider in committee as to whether it is a question for the minister.

Ms HARTLAND — I do not quite understand why that question cannot be answered.

Mr VINEY — We can have the other question, but not yours.

Ms HARTLAND — Right. Could you explain why that question cannot be answered?

The CHAIR — Ms Hartland, I think it is inappropriate to put a question to the witnesses that asks them to speak in effect on behalf of the Minister for Health.

Ms HARTLAND — I am simply asking would the minister have been aware — —

Members interjecting.

The CHAIR — Order! I call the committee to order. Ms Hartland, I will give you an opportunity to rephrase your question, and then I will move to Ms Crozier.

Ms HARTLAND — I thought my question was fairly simple. Would the minister have been aware that the review will occur in a few months time? I thought it was a pretty simple question. A yes or no answer would be fine.

The CHAIR — Mr Fletcher or other witnesses, you are free to respond but you do not need to speak on behalf of the minister or any other third party if you do not wish to.

Mr ALLEN — I am not aware, one way or the other.

Ms CROZIER — Very quickly, a number of submissions have stated that they think AHPRA is under-resourced. Is that your view?

Mr ALLEN — That AHPRA is under-resourced?

Ms CROZIER — Yes. Is that your view?

Mr ALLEN — No.

Ms CROZIER — That is fine. What is the cost of the administration for AHPRA?

Mr ALLEN — The cost of the — —

Ms CROZIER — Total administration.

Mr FLETCHER — In the current financial year, our operational budget for the year for AHPRA is $101.5 million.

Ms CROZIER — Thank you very much.

Mr VINEY — Just being clear, there was a ministerial council decision to determine that a review would occur not before three years?

Mr FLETCHER — The original intergovernmental agreement signed by COAG — —

Dr FLYNN — In 2008.

Mr FLETCHER — Made reference to the fact that there would be a review of the scheme not before the first three years of the scheme.

Mr VINEY — That was a COAG-signed agreement?

Mr FLETCHER — In the intergovernmental agreement.

Mr VINEY — Which is agreed by every state government, including Victoria, and the federal government.

Mr FLETCHER — That is correct.

Mr VINEY — I think that clarifies Ms Hartland's point, thank you.

Mr O'BRIEN — Thank you for the answer to my earlier question, and I certainly do not want to create more work in an effort to get to the heart of the issues. I will be subject to any committee direction as to how you answer it, but we would be happy for you, if a question has been answered or been solved, to cross-refer back to that. It is a matter of identifying what issues are live. By way of example, the submission from the Royal Australasian College of Surgeons talks about, in the third paragraph:

> … policy issues that confound and are difficult to resolve. An example of this is where New Zealand-based trainees who have a primary qualification from outside New Zealand or Australia need to be rotated through Australian hospitals to complete their training. The recognition of their registration is very difficult and time-consuming.

By way of example, do you accept that that is still a problem, and how are we going to resolve it?

Dr FLYNN — That particular problem is one of the areas, in terms of registration of international medical graduates, that the medical board is currently working on. We have developed a policy, which we are about to go out and consult on, on that particular subgroup of people who are in training.

Mr O'BRIEN — Thank you; that is why it is helpful to go through this process. Another one in relation to the regional problem — if I could just ask you to summarise — there is a concern that some international health practitioners are not adequately supervised. I was just wondering if you could explain the current process for assessing and supervising international health practitioners, and do you consider those processes to be adequate?

Dr FLYNN — We have a set of guidelines around supervision, and when the registration committee in the particular state — in this case in Victoria — is assessing an application for somebody who is working with limited registration in an area of need or in a postgraduate training position, they do that in the context of the available supervision and the signed-up agreement with the nominated supervisor with a specified level of supervision, how much contact there is to be between the supervisor and the doctor being supervised, whether it is in relation to every patient or every day or how it is to be set up. We have just recently agreed to establish another working party to review the supervision guidelines and decide whether they need any further modification.

There are potentially some conflicts of interest around supervision, so sometimes it is in both the practitioner's and the supervisor's interests that the practitioner is working. Sometimes we get very positive work reports from a supervisor until that employment relationship for some reason breaks down and then we get less positive supervision reports, and it is always important to explore what is the real situation here, but in general the model that we have provides many international medical graduates working in areas of need who would not otherwise be providing services for the community, and I think overall it works reasonably well.

Mrs PETROVICH — In the AHPRA submission there is a reference to the national law and how the confidentiality provisions make it more difficult to provide information to notifiers than under the previous scheme. Can you explain why this is the case and what you recommend ought to be done about it?

Mr FLETCHER — This was the reference I made in fact here about the issue of providing information to notifiers, and the particular issue is that in a circumstance where a board might decide to take no further action in relation to a practitioner, essentially the law limits what we are able to say back to notifiers. Where they decide to take action what happens is that, typically if there is, for example, a condition associated with a person's registration as a result of that action, then that will obviously appear on the national register, so the person would know what has happened. I think it is more problematic where it is a decision, as I say, that there are not grounds for further action. I think there are things we can do administratively to improve our processes around that, but I think we have also flagged that there may well be, insofar as the national review goes, if it does look at any element of the national law that may well be an area to have a closer look at to see whether there are any improvements that could be made in that area.

Mrs PETROVICH — So you are saying that should be something that is flagged in the review?

Mr FLETCHER — I think if the review is going to look at the national law, that would certainly be one area we would highlight that ministers might want to pay some attention to.

Ms CROZIER — We understand there are a number of issues in relation to the implementation process, and you have highlighted those in your submission, and also the Senate inquiry undertook that extensive review, and I think many of those questions were detailed in that particular inquiry. I am just wondering whether you could comment in relation to the Senate inquiry's recommendations in relation to what they have proposed to AHPRA and what AHPRA thinks, or have they implemented or undertaken all those recommendations that were put to them by that inquiry?

Mr FLETCHER — As you would be aware from the report, a number of the recommendations were directed to different audiences, so there were some that were specific to AHPRA and the national scheme, there were some that were made to the commonwealth and also to ministerial council. A lot of the issues in the recommendations were about how we dealt with a particular one-off set of issues to do with some of the registration where there were concerns about the earlier registration and the renewal of practitioners under the national scheme, and we certainly put steps in place to make sure that there was no disadvantage to anybody if there had been any administrative error on our part in that early part of the scheme. I made reference before to the service charter, for example, so that was a direct recommendation of the Senate committee and, as I have said, we have acted to put that service charter in place. We have certainly addressed any of the recommendations that were specifically targeted towards us. As I was saying, in a sense many of them reflected a particular set of issues at a point in time.

Ms CROZIER — I know there are 14 different practitioner groups that are currently registered with AHPRA. Do you believe that other practitioners should come on board?

Mr FLETCHER — That would not be a decision for us; that would be a decision for the ministerial council, and if it did want to bring new professions into the national scheme, it would need to amend the national law because all of the professions in the scheme are identified in the national law.

Mr O'BRIEN — Just by way of another example of an important question, in the AMA's submission it says on page 2:

> Information provided by AHPRA as to the basic standards to be met for registration have at times been unclear or non-existent and led to uncertainty and confusion among the profession, employers and AHPRA staff themselves.

What do you say to that sort of criticism in relation to registration information?

Dr FLYNN — It is it is a non-specific criticism, so I do not know what it refers to.

Mr O'BRIEN — Yes, it is.

Dr FLYNN — But all the registration standards required for medicine, given that this is a submission from the AMA, were in place prior to the establishment of the national scheme and were available on the medical board's website, so it is hard to know what it was that people think was unclear at that time.

Mr O'BRIEN — It may lead to that communication problem with the board whereby individual applicants had to go through one scheme in different states but within a state they had to go through the various different processes of the structures that remain. You have acknowledged some communication issues and maybe some differences. Are you able to flesh out those problems a little bit further and also what you are trying to do about them?

Mr FLETCHER — Yes. In my presentation I made reference to the fact that we have a designated customer service team in Victoria that is the point of first contact for any practitioner or member of the community who is seeking information or advice in relation to the national scheme. Those staff are obviously trained to deal with the queries of practitioners. If there is a query that goes beyond providing general information and needs a more specialised set of advice, then there are clear business rules for those calls to be appropriately referred to more experienced staff to deal with within the registrations and notification areas. I believe we have made substantial gains in terms of our customer service. As Dr Flynn said, it would be helpful to understand whether there is a specific issue that AMA has in mind when it makes that point. I think the general point of making sure that we continue to get feedback and give our customers the best possible experience is one that we will continue to be very attentive to.

Ms CROZIER — Mr Marty, in your presentation you talked about opportunities for improvement. In your submission you particularly speak about the lack of harmonisation of drugs and poisons legislation between states and territories. I think this is an area in which some reform can be undertaken, perhaps in that review or collectively. I am interested as to how you think that can be achieved.

Mr MARTY — How long have you got? It is a hobbyhorse of mine because it is particularly difficult in pharmacy. For every practitioner that has a trans-border practice there are barriers. For instance, in Coolangatta-Tweed Heads I know one pharmacist who owns pharmacies on opposite sides of the road. It is divided by the middle of the road and yet there are two totally different sets of requirements for him. A prescribing nurse practitioner in Albury could write a prescription that could not necessarily be dispensed in Victoria. This is a practical thing that we need to get over. What has occurred in the past needs to be overcome.

At the moment Health Workforce Australia has a health practitioner prescribing project, and I am on the project steering committee. A serious consideration is that this will be a barrier to extending the prescribing roles of other professions that are looking at this. There is a lot of work being done on this issue, but the implementation phase will be delayed unless there is a harmonisation of drugs and poisons legislation. The project looks at how practitioners are treated as well as offences — for example, dealing with a possession or trafficking charges is different across jurisdictions et cetera. I am sure that Ms Carlton gets sick of me raising this issue. It has been a constant thing for years.

Practitioners now have the ability to move around rapidly. They might fill a need because somebody falls ill. The last thing they need is to suddenly realise that because they went from here to Queensland they cannot

prescribe or dispense like that because there is a different set of rules in place. So from my perspective it is a serious barrier to implementation.

Ms CROZIER — Do you think there was a gap regarding this issue when AHPRA was set up? It affects many practitioners, as you say, who have rights to prescribe drugs in one jurisdiction as opposed to another. Was that an oversight when AHPRA was set up?

Mr MARTY — I think it was outside the scope of the COAG review and policy at the time. I do not think it was seriously considered or given enough time probably in the hope that somebody might do something about it. Earlier this year we met with the AHMAC executive. Once a month we have a forum at which all the chairs of the boards meet. We took that opportunity and you can certainly bet I raised that issue then. I also raised it with the Queensland Minister for Health just two weeks ago.

I understand that there is some movement happening in the ministerial council, but my questions would be when and what. It needs to have some contributions. If you were able to make a recommendation — this is my opportunity, I guess — I think all of the other boards that are looking at prescribing issues would greatly appreciate it. It would help get the harmonisation process moving.

Ms CROZIER — I was going to ask about the action you have taken. So you have taken it to a number of state ministers?

Mr MARTY — It would have to go to the ministerial council. Each state and territory has its own drugs and poisons legislation which controls who can prescribe, possess, administer, sell and supply. Records have to be maintained. They are the practical difficulties that happen for practitioners across borders. You are forever worrying about whether you transgressed. 'Is it the same in this state or not?'. They are the difficulties practitioners encounter.

Ms CROZIER — Can I just clarify how many ministers you have taken this issue to?

Mr MARTY — It has certainly gone to all of them through the ministerial council. The Victorian minister is aware of my comments on this, the Queensland minister knows about it and probably two ministers ago in New South Wales. The progress and change of ministers in New South Wales has outstripped my ability to make submissions.

Mr VINEY — Welcome to Victoria. Who is the next one?

The CHAIR — Are there any further questions?

Mr O'BRIEN — I have one more question, if I could, regarding issues. At section 10, page 16 of your submission of 28 February, under the heading 'Accreditation: training future health practitioners', you state:

> It is also now possible to consolidate effort, improve efficiency —

et cetera. You also mention medical radiation practice. By way of example I am just going to refer to the Royal Australasian College of Surgeons submission of 30 January. The fifth paragraph of its letter states:

> The college of surgeons continues to arrange international scholarships that involve hospital secondments for surgeons from Pacific-based countries. Although they are in Australia for a short term and are in a closely supervised/observed status their registration review is sometimes viewed as the same as international medical graduates who wish to take up permanent roles. Unfortunately AHPRA's officers are often unaware of the specific regulations applicable to 'Limited medical registration for postgraduate training supervised practice' and provide both variable and additional interpretations of the requirements.

This is another specific instance. Could you give us a response to that particular criticism?

Dr FLYNN — Is that the same issue as the one you previously raised?

Mr O'BRIEN — About New Zealand, yes.

Dr FLYNN — This is about international medical graduates who are undertaking their training, or who have just completed their training, coming into our country for further training and usually going back home to work. That is a very important contribution Australia makes to the education and training of practitioners, often from underdeveloped countries. It is true to say that the policy requirements around that were not very clear. It was

the one piece of the pathway for international medical graduates that was not very clear. As I said, partly in response to dialogue with the college of surgeons we have developed a new policy which we are about to put out for consultation. Once the policy framework becomes clear, then the operational direction to the staff who are dealing with those queries will be clearer too.

Mr O'BRIEN — We will have discussions amongst ourselves about how we orchestrate this, but there are also submissions that have expressed disappointment with AHPRA's investigative procedures. If a notifier or health practitioner feels they have been let down in these investigation processes, what recourse is available to them?

Mr FLETCHER — If they believe that AHPRA or the board for that matter has not followed the correct process in relation to how that notification has been dealt with, in the first instance they can make a complaint about that to us or the board. If they are not satisfied with the response to that, they can then go to the National Health Practitioner Ombudsman, which is the separate, independent office that can then review the process. They cannot review the outcome of the decision, but if there is concern about the process that has been followed, they have recourse to the Ombudsman.

Mr O'BRIEN — Do you have recommendations to improve that process? It is hard — again you have to go back to specific complaints, and some of them may be confidential, sensitive for various reasons or subject to all sorts of difficulties in terms of legalities, but can you provide recommendations regarding improvements?

Mr VINEY — That is assumed when you think there is a problem.

Mr O'BRIEN — That is right, but do you accept that there is a problem there, or is it something you think is working well?

Mr FLETCHER — I think the wider issue is about the information that we can provide to notifiers, particularly if there is a decision for no further action to be taken. I think I have highlighted that there is more we can do in that space, and there may potentially be some amendment to the law that might help in that area. We have not raised any specific concerns in relation to the wider issues of how we deal with administrative complaints about how the process works and how the Ombudsman deals with that. From our point of view, if there is a concern from a practitioner, it has served the scheme well to have an independent Ombudsman who can review how we have dealt with things.

Dr FLYNN — Just to add to that, there will always be practitioners and notifiers who are unhappy about the outcome of their complaints. The thing we need to do is make sure they understand what we have done and why we have done it. There probably are things we can do, but we are constrained by the law in terms of information with some of these. But we cannot always assume that they will be happy with the decisions we have made. In any set of circumstances when people make judgements about things not everyone will be happy with the judgements that they make.

Mr O'BRIEN — There is the famous phrase about natural justice and making sure that they feel they have had a fair hearing and that they receive the reasons for a decision. You did identify that there were some restrictions in the legislation. Can you identify them?

Dr FLYNN — There is no issue in terms of the information we provide to practitioners, but we cannot tell notifiers anything beyond what goes on the public register. So if there is no outcome that is recorded and no reprimand, conditions, undertaking or suspension, all we can do is to say that the matter has been investigated and no further action is being taken against the practitioner, which is unsatisfactory from the point of view of the notifier.

Mr O'BRIEN — Do you have anything additional to Mr Fletcher's answer as to how we act to change that or are we just accepting — —

Dr FLYNN — It is in the law.

Mr O'BRIEN — Yes, so the law has to change. Do you know what it should change to? No doubt there would have to be a caveat in the form of notification to protect the other issues. I will leave that. Perhaps that is something on notice that you can come back to us with at another time.

Mr ALLEN — Perhaps if I can add, one of the other set of initiatives this scheme has been able to take is to build the role of consumer representation much more securely into the scheme. In the end the decisions about changing the law will be decisions of ministers and parliaments. The review process will be one that we can be confident consumers will feel more empowered to feed their particular reviews into going forward because they have the sense that the scheme is more open to their perspectives. It does not mean there is necessarily an easy answer to resolving sometimes difficult balancing, but there is certainly a much more positive view amongst health consumer groups now about their access to at least putting forwards their perspective on the scheme, and I think there is a confidence that the scheme, or AHPRA and the boards, are committed to looking constructively at suggestions people have about how we can improve their satisfaction with the overall operation.

Mr O'BRIEN — That is what we accept the decisions will be to parliaments, but what are your recommendations and advice from your experience? Also your ideas on the criticism you accept as valid and that which you have valid reasons for defending is most helpful.

Mr MULLALY — Could I just add one last thing? The question arose from the college of surgeons talking about unsatisfactory outcomes for medical practitioners. It is always open to a health practitioner to appeal. That is available if a board takes a decision that they do not believe is right. Most of the sanctions and conditions, reprimands and so on are appealable, and that is appropriate, so that is that procedural fairness and natural justice.

Mr O'BRIEN — Is that the case for notifiers, though?

Mr MULLALY — No, it is not. It is not open to them under this legislation to appeal a board decision. The matter is always between the practitioner and the practitioner's board, with the notifier being an informant to that if you like. It is often a difficult concept for notifiers who see themselves as complainants to actually observe, but that is what the regulatory scheme is about: boards regulating the practitioners.

Mr O'BRIEN — There has been a lot of reform by way of parallel with the role of the victim in the criminal justice system, which have had analogous issues to some extent.

Mrs PETROVICH — We heard earlier that expenditure of AHPRA was $101 million. The previous state-based system was considered cost-effective by many, and it paid for itself via registrations. Is this the case for the current scheme?

Mr FLETCHER — It is totally funded by registration fees. There is no government funding. Is that what you are asking?

Mrs PETROVICH — Yes.

Mr FLETCHER — Yes, that is correct. It is completely funded by registration fees and in addition there is no cross-subsidisation between professions. Each profession has to pay their own way. The medical board charges, for example, have to meet the complete costs of what it costs to regulate medicine in the national scheme, and the same is the case for all professions in the scheme. Probably just to add for completeness, the costs of AHPRA are shared between the boards. What we have is a formula which we have independently validated and negotiated with the boards, which essentially reflects a share they pay of our operating costs of that $101 million based on the proportion of work we do on behalf of that particular board, and that looks both at issues of volume and complexity in terms of the work that we do. For example, around half of our notifications are associated with medicine, so medicine obviously ends up paying a bigger share of our costs around the administration of notification systems than other professions might do.

Mr VINEY — I think it is really important to get that clear. The administrative cost of AHPRA, which if you like is the administrative oversight of all of the boards, did you say that was $1 million?

Mr FLETCHER — It is $101 million.

Mr VINEY — But there are the costs of the individual boards — —

Dr FLYNN — No. Mr Viney, when I was the president of the Medical Practitioners Board of Victoria, Mr Mullaly was the CEO of the Medical Practitioners Board of Victoria and the board paid his salary and all of

the staff of the office that we had in Lonsdale Street. That office no longer exists. All of the staff are AHPRA staff, so as the chair of the medical board I do not have a physical office; I do not have my own staff. All of the staff are AHPRA staff. AHPRA do the work of the boards. The large bulk of the revenue that is collected from medical registration fees is contracted with AHPRA for doing the work.

Mr VINEY — So that is worked out on an agreed formula board by board?

Mr FLETCHER — Yes, and we publish the proportions in our annual report.

Mr ALLEN — The other aspect of the change that obviously varies between states and territories is, for example, that serious matters go to tribunals. There were various arrangements around the states and territories about whether those costs were borne by the government of the day. They are now borne by the registrants. We pay VCAT for services provided and all other jurisdictions operate in the same way. There is quite a lot of changing of the underpinnings or the assumptions that effected the cost build-up of the overall scheme. You pick through each of them one by one and you start to see why the boards particularly formed decisions that they needed to strike a registrant fee level that ensured that they were able to meet those costs and the liabilities going forward.

The CHAIR — Mr Mullaly, Dr Flynn, Mr Fletcher, Mr Allen and Mr Marty, thank you very much for your submissions and your preparedness to answer our questions. Thank you for attending the hearing this evening.

Committee adjourned.