# 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 — 11 December 2013

Members

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

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

Staff

Secretary: Mr R. Willis

Witnesses

Mr P. Allen, Chair, Agency Management Committee;

Mr M. Fletcher, Chief Executive Officer;

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

Mr M. Gorton, Member, Agency Management Committee; and

Mr R. Mullaly, State Manager Victoria, Australian Health Practitioner Regulation Agency.

**The CHAIR** — I declare open the Legal and Social Issues Legislation Committee public hearing in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency. In accordance with the guidelines for the hearings, I remind members of the public gallery that they cannot participate in any way in the committee's proceedings. Only officers of the committee secretariat are to approach committee members. I ask that you all ensure that your mobile telephones are turned to silent or switched off.

I wish to put on record that the purpose of this inquiry has been to examine the performance of AHPRA and the wider national registration and accreditation scheme in terms of its cost-effectiveness, regulatory efficacy and ability to protect the Victorian public. The committee is not able to act as a form of tribunal or system of review with respect to specific complaints against medical practitioners or other individuals.

I welcome the witnesses who are in attendance this evening: Dr Joanna Flynn, chair, Medical Board of Australia; Mr Peter Allen, chair, agency management committee, AHPRA; Mr Michael Gorton, member, agency management committee, AHPRA; Mr Martin Fletcher, chief executive officer, AHPRA; and Mr Richard Mullaly, state manager Victoria, AHPRA.

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 a few days.

I understand that you wish to table a document as part of your evidence tonight which provides feedback on earlier evidence received by the committee and provides an update on key issues. Thank you for this material, which the committee will make public on its website along with the transcript from tonight's proceedings.

Again, thank you for your assistance with the inquiry earlier this year and for providing additional documentation, which we have received over the last few days. I also thank you for your attendance this evening and the further information you are providing to us. I now invite you to proceed with a brief presentation to the committee, which will be followed by members asking questions of you in relation to this inquiry. Thank you again for being before us this evening; we do appreciate your time.

**Mr FLETCHER** — Thank you, Chair, for this opportunity. I know the committee has received a lot of information, and we look forward to answering your questions. In this 5-minute opening I would like to briefly clarify some of the facts about practitioner regulation in Victoria. There is an enormous amount of information I would like to convey. However, I will not repeat the content of each slide; rather, I will highlight important facts.

**Overheads shown.**

**Mr FLETCHER** — Firstly, I turn to accountability. The design of the national registration and accreditation scheme and its legislation delivers clear accountability to the community, the Victorian health minister and the Victorian Parliament. There is a comprehensive set of checks and balances delivered through the distinct roles and responsibilities of each of the main players, and the additional information we have provided to the committee tonight gives some further detail about who is accountable for what. Of course the common purpose of all involved is to protect the public.

I would like to reinforce the fact that the health minister in Victoria has significant powers over regulation in Victoria, both as minister and as a member of the ministerial council. This slide summarises those powers. He can seek and receive advice on local matters now. The minister also has the power to appoint the state boards and to adjust the mix of community and practitioner members on state boards, which I know he intends to do to increase community member involvement. There are community members on all national and state boards.

The national scheme has been a significant national reform, but in practice — as is summarised on this slide — medical regulation remained largely unchanged in Victoria after 1 July 2010. Many features of the arrangements in place prior to 1 July have been maintained within the framework of the national law, which is largely built on the previous Victorian legislation. Indeed Victoria was a leader in shaping the national law. In effect, the national scheme delivers state-based decision making for notifications about medical practitioners within the framework of national standards.

Community confidence in our work is vital, and an important part of this is how we work with the health services commissioner, so it does not matter whether a person raises their concern with the commissioner or AHPRA, we jointly assess the risk and make sure that the matter is dealt with by the right agency. The way this works is much the same as it was before. There are clear roles and good communication.

I know the committee has heard evidence from some consumers that the joint consideration process is not working in their interests. Given our focus on public safety, there will always be issues that concern consumers which do not meet the risk threshold for boards to take action under the national law. We believe that many of these concerns are best addressed by the health services commissioner, either in tandem or after the board process is complete. However, the commissioner currently believes that their legislation prevents them from dealing with matters that have been dealt with by a board, even when no further action has been taken. This is not a national law issue, but clearly it is significant for consumers. We hope that this issue will be addressed in the government response to the review of the health services commissioner.

We are also taking responsibility for what we can change. I have asked Victoria's consumer advocacy group, the Health Issues Centre, to work with us and our community reference group to look at what steps we could take to address these issues — for example, how we can improve communication with notifiers.

I know the committee has also been interested in questions of performance, and we are very happy to answer questions about how this works. In brief, in the jurisdictions AHPRA is responsible for, there is a clear and consistent notifications process with standard operating procedures for each stage. There are key performance indicators for the timeliness of each stage of the notifications process. This is new and more rigorous than what has ever existed in Victoria. Performance measures such as these did not exist universally, and there was wide variation in performance across jurisdictions and professions prior to the national scheme. We will start public reporting on our performance against these KPIs from 2014–15, in addition to our annual report. This exceeds the reporting requirements of the national law, and we are also benchmarking internationally and across Australia. If more is needed, the minister could require us to report to him and Parliament against these or other performance measures for the management of notifications in Victoria, with minor local legislative amendment if needed.

There is a comprehensive framework for performance management in Victoria and to address any outliers in performance. There is both an internal management review and independent external review. This is designed to ensure that risks to public safety are being managed, including while an investigation is under way.

I am aware that the committee has visited Queensland and that it was interested in the changes there, which will be implemented next year. By way of background, there have been a set of unique challenges in Queensland that are different from Victoria. There is no evidence of light-touch regulatory decision-making in Victoria. The role of the health complaints entity, the HQCC, was different — it was blurred and overlapping in ways that the relationship with the health services commissioner here in Victoria is not.

The difference in open matters at the start of the national scheme is also significant. Two-thirds of the matters looked at by the Forrester review were legacy matters that started under the former Queensland arrangements and transitioned as ongoing matters to the national scheme. While the same sorts of issues do not exist in Victoria, we have increased the number of investigators and lawyers to manage a growing number of notifications — nearly 50 nationally and 9 new investigators and lawyers in Victoria.

Finally, I know that the committee is interested in the cost of regulation in Victoria. In short, each profession must pay its way and meet the full cost of regulation. There is no cross-subsidisation between professions.

We have provided additional information in our update, and we would be happy to answer questions.

**The CHAIR** — Thank you very much for that overview, Mr Fletcher. As you correctly say, I understand that you have been undertaking a number of reviews since our inquiry commenced almost 12 months ago or thereabouts, and we thank you for giving us an update about the work you have been undertaking. You rightly addressed a number of issues that we are looking at. In your statement to us just now you said that community confidence was vital, and you referred to complaints to the right agency in terms of the complaints process, and obviously we have heard a number of issues in relation to the complaints process, and I would just like to understand a bit more about that.

In your annual report of this year entitled *Regulating Health Practitioners in the Public Interest*, in his foreword Mr Allen said:

> For the community, the national scheme delivers more robust and transparent protection of public safety than existed previously in any one state or territory regulation system.

Again I go to the subject matter of the complaints process, and I think this is what we are trying to understand a little bit further. In looking at the notifications, I would like to take you to the figures on page 143 of the report. In 2013 there were a total of 8014 notifications. From New South Wales there were a total of 2972 and from Queensland 1957. From my calculations, that is roughly about 60 per cent or thereabouts of total notifications. My question to you is: if we have a national scheme with 60 per cent of notifications coming out of those two states that have gone their own way, how can it be a national scheme when we have a fragmented process, because Queensland, as we know, has opted to have a different system and New South Wales never came on board? Can you explain to us the discrepancies there and why that fragmentation is there in a so-called national scheme?

**Mr ALLEN** — The first and primary responsibility of the scheme is to register people appropriately qualified to practise. That is done nationally and continues to be done nationally. Associated with that there is the partnership arrangement with accreditation authorities to ensure that training providers are appropriately equipped and qualified to provide training that will graduate people competent to practise professions.

There are different arrangements — and always have been slightly different arrangements in each state and territory — about how complaints are handled and what bodies exist that complaints can be made to. The interface — in Victoria with the health complaints commission and the regulator, AHPRA — is one this committee is obviously very interested in, and it is one that exists in slightly different ways in different states and territories. It is a relationship that will continue unless a health complaints commission is abolished in any state or territory and AHPRA assumes greater roles.

So it is part of the national scheme — it always has been part of the national scheme — to have two parts of a process that deals with complaints. We work with those bodies in each state and territory in slightly different ways to ensure that to the greatest extent possible the experience for the person making the complaint or registering the concern is as well coordinated as possible. That is always going to be an area where there are opportunities for improvement. I think what we find is that there are different challenges in each state and territory or different challenges around individual cases. It does not mean that the national scheme does not operate – particularly with its core function – which is registration and the review of regulation in the light of the outcome of any complaints process to ensure that practitioners are able to register once, practise anywhere.

**The CHAIR** — I think we are very aware of the registration process. We understand there were some significant issues that arose with the initial implementation of the scheme, and we understand that the Senate inquiry has been undertaken and that many of those issues have been resolved. I am particularly interested in the complaints process and if you are saying that this national scheme delivers more robust and transparent protection of public safety than existed previously. However, in your answer just then you spoke about different arrangements for how complaints are handled, there are two parts of a process to deal with the complaints process, you work with those bodies and there are different challenges from each state and territory. So I suppose what I am asking is: there seem to be a number of difficulties in the national scheme undertaking the complaints process, which you have just said yourself has challenges.

**Mr ALLEN** — There are always going to be challenges in managing complaints.

**The CHAIR** — I understand that; I can see that.

**Mr ALLEN** — And almost every case is different. There are different arrangements in different states, but the core arrangements between the health complaints authority and AHPRA as the regulator are ones that are handled very successfully. They are handled very successfully in New South Wales, where we have got substantially different arrangements. They are handled successfully in Victoria.

**Mr FLETCHER** — Can I perhaps just add to the comments that Mr Allen has made?

**The CHAIR** — You can, Mr Fletcher, but can I just take you up in terms of one of the issues about the health services commissioner that you raised here. I cannot remember the phrase you used, but you said the

complaints went there, and I got the impression that you felt that that was a body that may not be necessary if AHPRA is undertaking the complaints nationally.

**Mr ALLEN** — No.

**Mr FLETCHER** — No.

**The CHAIR** — Or have I misinterpreted you?

**Mr FLETCHER** — I think our view is that the joint consideration process is a very important process, because it basically means that a member of the community can lodge a complaint with AHPRA, they can lodge a complaint with the health services commissioner, and there is the requirement for a joined-up discussion to assess the risk and work out who is the appropriate agency to deal with that matter. So we think the joint consideration process works very well. I think the issue that appears to be more of an issue in relation to the current legislation for the health services commissioner is whether they are able to act on a matter once it has been considered by a board or in tandem with a board. That is why I made the point in my opening comments that I think we would welcome the government response to the review of the health services commissioner, because we understand from the discussion paper around that review that these were some of the issues that that review was considering in looking at how improvements might be made.

**The CHAIR** — And in your opinion, what is the appropriate time frame for when you have a complaint and there is that joined-up system between the health services commissioner and yourself? What is the appropriate time frame?

**Mr FLETCHER** — We are talking about a process that in most cases occurs within days, and if it is a question of high risk, then we may move even more quickly, because of the potential need to take immediate action to protect the public in relation to that practitioner.

**The CHAIR** — Are you confident that that happens in every single situation currently?

**Mr FLETCHER** — I am very confident that the processes we have for the receipt and initial risk assessment — risk evaluation of a complaint and an assessment — are working well. The issue I highlighted in my opening comments was that we recognise that one of the areas we have put additional resources in particularly is in the time frames for investigation, because we would like to look at how we can improve the time lines for investigation. So the current median for an investigation is around seven months. We would like to bring investigations much more under six months, and so the additional resources are to look at how we can achieve that.

If I can just also add that of course even while a matter is under investigation if there is a question of risk to the public there are powers under the national law for a board to take immediate action to put whatever restrictions might be necessary on the practice of that registrant, including potentially suspending them, until the matter is fully addressed.

**The CHAIR** — And you are absolutely confident that is what occurs currently?

**Mr FLETCHER** — I am confident that those processes are working well in Victoria.

If I could also pick up on the point that you asked about consistency, I think there are three elements of consistency from our point of view that are particularly important when we talk about national consistency. Firstly there is the fact that there are national standards set by national boards which are the requirement for practitioners to meet and then obviously what is considered if there is a concern about their performance, their conduct or their health, so there is the importance of the national standards in that area; I think secondly it is important that a similar level of risk is dealt with in a similar way around the country and there is not variation because of the accident, if you like, of where you happen to live; and thirdly that the outcomes of any board action in relation to a notification feed into the national registers so that there is a single source of truth for the community to look up information about practitioners and any restrictions that there might be on their practice.

As Mr Allen has said, we inherited in the scheme an established system in New South Wales, and we have developed an effective interface with that system. At the moment, as you know, Queensland is proposing to move to a new but different arrangement to Queensland — it is a co-regulatory arrangement, but it is different.

That is yet to be established, but obviously once that is in place we will look to work smoothly with that set of arrangements as well.

Fundamentally our message is that we think the model of dealing with notifications in Victoria is viable and in many ways is working well. It is not to say that it is perfect and it is not to say that there are not areas for improvement, but we believe the model is working well and suits the context of Victoria. If there are issues about accountability and getting greater local oversight of what we do, we think there are ways that that can happen through relatively minor amendment to the adopting legislation. The minister could say, 'There are these performance indicators; I require you to report regularly to me and to Parliament about your performance in relation to that'. We think that that is something that could be considered, rather than throwing away a model that we think is largely unchanged and is serving the Victorian community well.

**The CHAIR** — Thank you. I want to move on to other members, but finally, in relation to the health services commissioner and what their role is to do — investigating complaints — why shouldn't they investigate all complaints then here in Victoria if you say the local model is working well?

**Mr GORTON** — Can I perhaps provide a bit more background? The health services commissioner in Victoria is not a complaint-handling body; it is a complaint resolution body. The powers of the health services commissioner are to work with the parties involved, bring about a conciliation and hopefully achieve an outcome between the parties which may involve compensation, apology and those sorts of things, but it cannot impose any action and it cannot deal with the professional status of the individuals.

**The CHAIR** — But the boards can?

**Mr GORTON** — But the boards can.

**The CHAIR** — Correct. So we have still got that local involvement here in Victoria —

**Mr GORTON** — Correct.

**The CHAIR** — for resolution and complaints to go through rather than going to a national body?

**Mr FLETCHER** — You have that for the national scheme as well. All of the decisions — for example, about medical practitioners — are made by a local medical board appointed by the minister here in Victoria, made up of local practitioners and local community members who have powers to exercise full decision making in relation to practitioners. We work with the health services commissioner and we work with VCAT, so it is fundamentally — —

**The CHAIR** — I want to move on to the other members, but you are just the administrative arm of that process then?

**Mr FLETCHER** — AHPRA administers and supports that work. Here in our Victorian state office, for example, we support the medical board to discharge those responsibilities.

**The CHAIR** — Thank you. I will move on to other members.

**Ms MIKAKOS** — Thank you very much for your presentation. Given that we are discussing the complaints process, I think I might perhaps kick off with my question around that, and particularly in relation to notifiers not having a right of review, as was previously the case where there is a decision that no action be taken. Are you able to comment on that as to whether you take the view that that is necessary that notifiers not have that right of review? Do you advocate a change in relation to that?

**Mr FLETCHER** — At the time that ministers developed the legislation — the legislation reflects the work that ministers did prior to the commencement of the scheme — in that provision which existed in the previous Victorian legislation there was not support for that to be in the national legislation, so it is not a feature of the national legislation. Essentially we and the boards administer the legislation as agreed by ministers and as subsequently passed by parliaments.

The other comment I would make is that of course there is an independent ombudsman for the scheme, so certainly if a notifier has a concern about the process of how we have dealt with a complaint, either from the

AHPRA point of view or from a board point of view, they are able to have that followed up through the ombudsman, but it is about the process of the complaint, not about the outcome.

**Ms MIKAKOS** — Thank you. I did understand that it was a feature of the old regime, which is why I am asking about that particular issue as to whether it should be considered for change. Obviously we get consumers who are aggrieved by the process, and they are particularly aggrieved when they feel that the decision is that no action be taken. Do you have statistics as to how many of those would then go to the ombudsman?

**Mr FLETCHER** — In the annual report we report on our administrative complaints. Of about 680 complaints we received, I think just over 100 — about 111 — related to some element of the notifications process; they were complaints we were dealing with. I am not able to comment on how many the ombudsman is dealing with.

Perhaps the other point I could make is that of course, as you are aware, ministers are currently looking at the three-year review of the national scheme, although the terms of reference for that are not yet formally announced. We would expect that one of the elements that review will look at is the legislation. If there is a view that there are weaknesses in the legislation or things that need to be amended, then I think that would be the forum for those sorts of issues to be looked at in more detail.

**Ms MIKAKOS** — Given that you have touched upon that three-year review, are you able to give us an update as to what the likely time frame is for that?

**Mr FLETCHER** — We cannot, sorry. I think that would be a matter to — —

**Dr FLYNN** — It is independent of us.

**Mr ALLEN** — Under the leadership of the ministerial council.

**Mr FLETCHER** — Yes.

**Ms MIKAKOS** — So the new federal government has not given any indication — —

**Mr FLETCHER** — It is not the federal government. It is the ministerial council, which is the state and territory health ministers and the commonwealth minister who have joint responsibility for the review.

**Ms MIKAKOS** — I might jump around across different issues, but I want to come to the issue of the minister's responsibility. You referred to that in your presentation earlier. Did you take the view that the minister had a more direct responsibility under the previous act? Could you perhaps explain to us further the minister's responsibilities under the old legislation and the current system? I am talking about the Victorian minister.

**Mr FLETCHER** — Yes. I was not here when we had the Victorian act, but I am happy to talk about the national. Richard, is there anything that — —

**Mr MULLALY** — Now, as Martin has said in his introduction, the Victorian minister undertakes the recruitment process for board members relating to medicine, nursing and psychology in Victoria. There is an ongoing relationship between the Department of Health, the minister's office and AHPRA. He oversights the number of members that can be on different boards and has exercised that in recent days with respect to adding a community member to the Victorian Board of the Medical Board of Australia, which we welcome. He can request protected information and data, he can seek and receive advice about local matters, he controls board membership and mix, as I said, and he makes these appointments.

In general terms there is not terribly much difference between that and the way the scheme worked prior to this, apart from the fact that he did have oversight into more of the board appointments. But when we take it as a proportion, his effect, board-wise, over the number of practitioners is around 80 per cent of those. In other words, psychology, medicine and nursing account for a larger proportion of practitioners within the scheme.

**The CHAIR** — What about those other practitioners that are affiliated with other boards?

**Mr MULLALY** — The ministerial council appoints the national boards, and those national boards appoint committees to oversee the individual practitioner issues relating to registration and notification for the practitioners in the state. For optometry the national board appointed by the ministerial council makes the appointments of local optometrists, for example, and community members to oversee registration and notifications.

**The CHAIR** — Just to clarify that last point, he does not have direct responsibility; it goes through the national boards.

**Mr MULLALY** — The national boards have oversight of that.

**The CHAIR** — Thank you.

**Mrs PEULICH** — I have a few questions, mostly to do with issues of transparency and accountability and your operations. I was very interested to hear Mr Fletcher concede that there is room for improvement — that it is a viable system but perhaps there are areas that need further work. We have heard before about the KPIs which have been introduced for each stage and that you plan to publicly report on those in 2014–15. Clearly that was not built into the system when it was established; it has been precipitated by other events.

I am interested in the fact that it takes an external event to have a three-year review. Can you talk me through the independent external process and the internal audit process? Also, in your PowerPoint presentation you mentioned that the Victorian Minister for Health has responsibility for oversighting your performance, yet in the summary of accountabilities in the national scheme, which we have here on paper, the issue of performance is not a dot point under the Victorian Minister for Health's responsibility. Can you talk me through some of those issues?

What I am interested in, and I accept that conceptually perhaps the scheme makes sense, is that there are insufficient checks and balances and insufficient impetus to monitor and report on performance and also to red flag issues where they occur, in particular as Ms Mikakos mentioned, for example, when there is a decision that no action be taken or when there are undue delays. I am interested in those cases that might fall through the cracks. What systems are in place at the moment to subject those to open and accountable review?

**Mr FLETCHER** — There are a few points in there which I will try and unpick.

**Mrs PEULICH** — They all go to the issue of governance, accountability and performance.

**Mr FLETCHER** — In terms of a general point of context, currently in the national law there is a single measure of performance as it relates to notifications, which is to say that we must conduct a preliminary assessment within 60 days. The fact that we have gone on to develop KPIs, to publish those — —

**Mrs PEULICH** — Since when?

**Mr FLETCHER** — I have said we are going to publish those from 2014–15, but even in our annual report this year there are five times more data tables than there was last year. Our commitment is to publish more and more data about our performance and to be as transparent as we can be about our performance, and we are going beyond what the national law requires us to do. We are taking the initiative in wanting to be on the front foot for all the reasons that we agree are important around the transparency of what we do and the confidence of the community and practitioners and ultimately governments in the work of the scheme.

**Mrs PEULICH** — What has precipitated that?

**Mr FLETCHER** — What has precipitated that is that we are a scheme that is now just over three years old and, as we have developed more and more and our data systems have improved, we have wanted to do this. It has been a direction of travel for us over a period of time, so it is part of the evolution, maturing and development of the national scheme. I would say it goes beyond what was in place for Victoria prior to 1 July 2000. What we are doing and what we are proposing to do is more than was in place prior to the national scheme.

The point I make about the minister in relation to accountability is that we have an accountability to him for performance. One of the key ways that we do that —

**Mrs PEULICH** — The acquittal of the annual report.

**Mr FLETCHER** — is through the annual report. The annual report is a key accountability tool, and that is tabled in every Parliament in Australia, including the Victorian Parliament. But we want to do more than that, and hence, as I say, our commitment — —

**Mrs PEULICH** — And we want you to do more than that too.

**Mr FLETCHER** — Yes. Hence our commitment to reporting publicly and hence the point that I made in my opening comments that, if you felt there was more we could do in that area, that could be required of us in the Victorian context.

**Mrs PEULICH** — Could you sketch out how that might occur?

**Mr FLETCHER** — For example, you could develop a set of key performance indicators or adopt the key performance indicators that we proposed for the timeliness of our processes. You could require us to report those regularly to the minister and the Victorian Parliament.

**Mrs PEULICH** — Outside the annual report?

**Mr FLETCHER** — Outside the annual report.

**Mrs PEULICH** — A red flag.

**Mr FLETCHER** — And, as I said, through an amendment to the adopting legislation, not the national law. If you needed to, you could legislate that requirement for us. That is there if there is a view that more is needed around accountability.

**Mrs PEULICH** — It is not necessarily our view, but I think there is the public view about that, and unfortunately the expectations of the community and the professions increase, so we look forward and not backwards. I guess all of us are expected to be transparent and accountable for what we do and also for our performance to be monitored and subject to review. I am interested in actually beefing that up.

**Mr FLETCHER** — Yes.

**Mrs PEULICH** — I am interested in your informed opinion, given you have applied yourself to how your performance can be improved. Any ideas so we can use that as part of our recommendations?

**Mr FLETCHER** — Yes. We would welcome that. As I say, I think the KPIs that we provided in the background information are a very important starting point. You also asked about the internal and external review processes.

**Mrs PEULICH** — Yes.

**Mr FLETCHER** — Which I think was the reference in this slide. Essentially what we have set out is a set of internal escalation processes where we regularly review performance data internally in the first instance to identify any issues that may sit outside what we require in terms of performance. There is reporting to our agency management committee, which is effectively our board — the board of AHPRA. We have a quality assurance program. We have an independent auditor, and Grant Thornton has been appointed as our independent auditor. For example, they are currently auditing compliance with our notification processes in all of our offices. Then the agency management committee has established an audit and risk committee, which is independently chaired. We also report performance to that committee. I think there are some quite robust internal mechanisms for performance reporting. Then of course we have the external accountability as identified there.

I think the only other point that I would just like to make is that timeliness is really important, and making sure that we do things well in terms of timing is absolutely important, but obviously ultimately what we are also interested in is making sure that boards are well supported to make effective regulatory decisions. There are circumstances sometimes where it is not possible to meet time frames — for example, if a notifier is unwell or if there is a court proceeding that has to take precedence over an investigation that we might be doing. But as I

said earlier, what we are able to do in that circumstance with boards is if there is a concern about a risk to public safety, restrictions if needed can be placed on the registration of a practitioner while those other processes occur.

**Mrs PEULICH** — Is there a need for a regular additional external review for the small percentage of cases where perhaps it has been deemed that no action should be taken or where there has been undue delay, and if not, tell me how it is catered for within the existing system?

**Mr FLETCHER** — Currently through our internal processes we would review every single matter that is sitting outside of a KPI, particularly as it relates to our investigation time frames, and we would require an action plan in relation to steps that are being taken to address that where there might be issues within our control in terms of our process, and that is routinely reported to the agency management committee. It is also routinely reported to boards, and if there is a concern from the boards or the Agency Management Committee about any element of that, we are able to take additional action. As I said in my opening comments, one of the things we have done, for example, is substantially increase the resources both in Victoria and nationally, and that was driven by a desire to make sure that we achieved a desired case target per investigator in particular, as an important part of maintaining the timeliness of the process.

**Mrs PEULICH** — In closing that particular line of inquiry, we have heard, for example, that the problems arise from the fact that no single person is responsible — it is not a single minister who is responsible but the ministerial council — and therefore the response times to issues can be slow or sluggish. You have already conceded that perhaps there is room for improvement in the monitoring of your performance by a state minister, such as the Victorian one. You would accept that that is a legitimate role that the Victorian health minister could play in monitoring the performance of AHPRA?

**Mr FLETCHER** — Yes, I think if the minister wanted additional assurance around our performance, then it would be entirely legitimate for him to seek that. He could ask us that now, and we would give him the information.

**Mrs PEULICH** — But I am not interested in special events; I am interested in a system that works and generates that as a matter of course.

**Mr FLETCHER** — We think that is entirely appropriate and legitimate, and we would work very hard to make sure those needs were met.

**Mr ALLEN** — It would be possible for the minister to request a regular report from the agency, which the agency would be happy to provide. I am not quite sure what the legal issues might be, but our accounts are audited by the Victorian Auditor-General. It may be possible for Victoria's Auditor-General to do a performance review, as he does in many aspects of government activity as part of his performance review schedule. The minister can request performance data from the agency at any time of his choosing.

**Mrs PEULICH** — But how can we institutionalise that? How can we build it into the system?

**Mr ALLEN** — I think the suggestions that have been made here today would be a significant addition to what already exists.

**The CHAIR** — Thank you for that clarification.

**Ms HARTLAND** — My focus tonight is around the notifiers. I was really interested to hear you say that you felt that the notifying process had improved. A number of the witnesses we have had, Jenny Morris and a number of other people, have indicated quite clearly that they do not believe that as notifiers they have been treated well or with respect. I note that you are working with the Health Issues Centre to improve communication with notifiers. Can you outline what you are doing?

**Mr FLETCHER** — One of the issues that I know was highlighted in the evidence from Ms Morris was that having made a complaint, initially to the health services commissioner, it was then very unclear to her what happened to the complaint, and then from her point of view there were a set of issues around the timeliness of communication and then ultimately I think a frustration that because there was no action that a board was going to take that there then appeared to be no pathway for the health services commissioner to pick up the matter and see what they might be able to do to assist.

I think from our point of view some of the issues that we want to work on with the Health Issues Centre and our own community reference group — which I might add Ms Morris is on and we are very pleased to have her working with us — —

**Ms HARTLAND** — And I think she will be a great benefit.

**Mr FLETCHER** — Yes, it is fantastic to have her there. It is really about: what do we need to do to improve communication, because how do we make sure that people are clear on what is happening to their matter and what the different roles, responsibilities and parts of the system are? In some of the update information we have provided we have included some of the additional information we have already provided for notifiers. There is the communication issue; there is then the question of making sure that the process is timely, and I think that goes to some of the discussions we have had about KPIs and the like, particularly from our point of view; and then finally there is this issue. We believe it would be helpful either if there was a way in which the health services commissioner could work in tandem with the board, so that different parts of a matter could be dealt with by the commissioner while the board is looking at a particular aspect that might be relevant, for example, to a practitioner, or if, following a board decision, there was a way the health services commissioner could then pick that matter up and possibly deal with the complaint areas that do not go to questions of public safety and public risk. We think that would be helpful as well.

As I said earlier, I think that is why we are hopeful — having seen the discussion paper and contributed to the review of the health services commissioner — that the government response to that may in fact address a number of those issues in the context of the legislation for the health services commissioner, which is really the issue here, because our own legislation does not stop, for example, a notification being dealt with in part. There is not anything in our own legislation that stops that happening. It seems to be more of an issue with the legislation here and how that might need to be amended.

It is about all of those sorts of elements, and really our aim is to improve the notifier experience because at the end of the day we are here for the community and it is important for all the reasons we have talked about around transparency, communication and understanding a process that there is confidence in the way the process works. Because at the end of the day, as I said, the joint consideration process is about making sure that the complaint gets dealt with in the right way, by the right person, as quickly as possible.

**Ms HARTLAND** — If we take the Jenny Morris case again, if someone with a similar complaint were to ring now — that is, be a notifier — what would the process be and how would that be managed?

**Mr FLETCHER** — I know, for example, that one of the things the health services commissioner has already done is make some changes to their information to notifiers that makes clear the fact that if there is a question of public safety or risk, then that matter may need to be considered by AHPRA and the board and that it would be a different process. So I think there is improved front-end communication already. The other part then, in so far as we are dealing with a matter, is to ensure that we are regularly communicating with the notifier. We certainly aim to communicate very regularly with notifiers about the progress of a matter, obviously to then make sure that the matter is dealt with in a timely way and there is feedback to the notifier.

One of the issues I raised with you though the last time we appeared before you was that there are some constraints in the national law about what we can tell a notifier, particularly in a circumstance where a board decides to take no further action. As part of our submissions to the ministerial council and as part of what we hope will be a look at the legislation in the context of a three-year review, we have certainly identified some areas where we think it would be helpful if the legislation could be amended to allow us to be able to say more to a notifier, especially in a circumstance where there is not a question of public risk in relation to what the board is acting on.

**Ms HARTLAND** — One of the questions that Ms Morris has posed to me and I think is worth asking is: how can AHPRA justify dismissing a notification on the grounds of insufficient evidence when a willing and able notifier is not even interviewed and their medical records were not collected?

**Mr FLETCHER** — I am not in a position to comment on the individual circumstances of Ms Morris's case obviously because of her own privacy and also because I think she has legitimately raised her concerns with the Ombudsman as well, and that process obviously will take its course. All I would say more widely is that every notification is reviewed individually by a board supported by AHPRA. The issue really is about a threshold for

public risk, which is the focus of the board: is there something about what this practitioner has done that raises a wider risk to the public that may need to be looked at more closely or may require some sort of restriction on their practice? In many circumstances that is not the case — it is not a question of wider public safety. As I say, in that circumstance we would like to be able to tell notifiers more than the law allows us to do at the moment, but that is the general sort of process of what happens in these sorts of situations.

**Ms HARTLAND** — I know I am probably going on about this a bit, but you are saying that things have improved, and I received an email from a separate person today and very similar concerns are raised in that email about the way that person has been treated. I do not have permission to reveal their name, and I will seek that, but I am really concerned that you are saying the system has improved and yet the evidence we are getting from notifiers is that it has not. Is it possible to get a report from the health services centre in a written submission or correspondence?

**The CHAIR** — Do you mean the health services commissioner?

**Ms HARTLAND** — No, the Health Issues Centre — if they could correspond with us about what is happening and if we could also get similar correspondence from the community members to see how they feel about the way things are working now?

**Mr FLETCHER** — My understanding is that the Health Issues Centre has provided a submission to the committee, and I think you heard from Mary Draper. Are you asking for some follow-up information about the scope of the work we are doing with the Health Issues Centre and the consumer resource — —

**Ms HARTLAND** — You are saying you are working with them to improve communication with notifiers.

**Mr FLETCHER** — Yes, so you would like some further information about that work.

**Ms HARTLAND** — I want it particularly about notifiers.

**Mr FLETCHER** — Okay.

**The CHAIR** — And it is correct — we have received a submission from them.

**Mr FLETCHER** — We can provide some follow-up information about the scope of the work that is being undertaken.

**Ms HARTLAND** — That is right, and also if we could have correspondence from the community members as to how they feel that is working.

**Mr FLETCHER** — The community reference group, about the work being undertaken by them?

**Ms HARTLAND** — That is right.

**Mrs MILLAR** — My particular area of interest is in relation to health programs, and I am particularly interested in a fairly recent press release from the nursing and midwifery board which states that they are looking to work with AHPRA and other health professional boards and are looking at the role of national and international health programs as a benchmark. Does this mean that a joint national health program for all professions is currently under consideration?

**Mr FLETCHER** — Let me make a comment about that in relation to nursing, and Dr Flynn may want to comment in relation to the work that is occurring in medicine in that area. As you know, basically there is a well-regarded and well-established health program here in Victoria.

**Mrs MILLAR** — Absolutely.

**Mr FLETCHER** — When there was funding that accompanied the transition to a national scheme to maintain that for three years the board undertook a national review to consider whether that was a model that might be adopted more widely. What emerged from that were very little consensus about a model for a national health program, not very many other examples of other health programs in other parts of the country and indeed a view felt strongly by some people that these sorts of services were much more of an employer responsibility

than the responsibility of a regulator — for example, in the context of employee assistance programs and the like.

The board did not believe that there was sufficient support or evidence to establish a national health program on the basis of the Victorian model; however, what they have agreed to do, working with AHPRA, is some further work, looking in a sense more widely than just in Australia, because there is very little experience, apart from Victoria and internationally, on models of health programs. In that context there is also an interest in looking at whether there may be scope for something that is multi-professional. For example, you might have a portal where a range of professions could potentially go, and then there might be more profession-tailored specific advice depending on what the issue is.

The board have agreed to work with AHPRA in regard to how that model might work. As you are aware, given that work occurring, the board have agreed to provide an additional two years funding to the program here in Victoria so that there is time for that work to occur, for there to be appropriate consultation on that and to develop what the longer term direction might be for a program that might be supported by the board.

It is probably worth, just for completeness, because the medical board has also been looking at these issues — —

**Dr FLYNN** — The medical board has taken a different approach to the nursing and midwifery board and to the other professions, because the medical board is strongly convinced of the need for a national doctors health program, and that belief has only been supported by the recently published study done in cooperation with the board by beyondblue, which surveyed nearly half of all Australia's medical practitioners, got a high response rate and found very significant levels of current and past mental health problems and distress amongst the medical profession.

The board has currently commissioned a piece of work to look at what that model should look at, what the governance model should be and what the accountability should be, and has set aside funding to fund a national doctors health program in all states and territories. How that will work structurally with the current state programs is an issue on the table for us to work through in conjunction with the profession, but we have a strong commitment to an equitable offer of delivery of doctors health programs around the country.

**Mrs MILLAR** — At this preliminary stage, what would you see AHPRA's role as being in that?

**Dr FLYNN** — The board as a board is a policymaking body — AHPRA does the work — so when we set up the arrangement AHPRA will administer that arrangement, administer the funds and the accountability arrangements, the reporting and so on.

**Mrs MILLAR** — Do you see any potential conflict for practitioners or other medical service providers in seeking treatment and support from an organisation that is also responsible for registration?

**Dr FLYNN** — No. Let me be very clear about this: we would not run the doctors health program; it would be completely at arm's length. Part of the preparatory work the medical board has done is to try and articulate very clearly our regulatory role in relation to impaired practitioners and public protection, which is quite separate from a whole range of things about access to health services and support that a range of doctors need. We need to be very clear about the thresholds for reporting to the board and the board taking action, but the whole sort of nurturing, pastoral care, support, triage, education and prevention is in the hands of a separate body, which would be funded by medical registration fees and run at arm's length from the board and from AHPRA.

**The CHAIR** — Dr Flynn, I seek some clarification from you, because that is a really important element. You are supporting your practitioners very strongly, I believe. If I look at the annual report on page 152, in that table there are — and correct me if I am wrong — significant increases in relation to mandatory notifications, particularly around practitioners who are affected by alcohol or drugs and around sexual misconduct, and if you look at the time frames, they have increased in recent years. It is hard to determine from this table in which particular practice it applies, but I would have thought that they are significant figures on the increase and that it could apply to a number of professions. Why shouldn't it be looked at in totality, if you like? Have you got a view?

**Dr FLYNN** — I think there are two ways of looking at that. Doctors are clear in their feedback to us that they would like a stand-alone doctors health program, and the board is clear that that is an appropriate thing for us to do. We do not seek to influence what the other boards might choose to do. We are very happy to talk about our reasons for doing that. There is a table there, table 129, which reports by profession, but for one year not across trends.

**The CHAIR** — I see that too. I was referring to the table at the top of the page, but thank you for those comments; I appreciate it.

**Mr O'BRIEN** — Thank you for coming. In response to some of the criticisms, just following on from this essential issue of accountability and protection of the public as well as transparency, we received a letter dated 23 September 2013 from the Royal Australian College of General Practitioners responding to some questions we had raised in relation to complaints made about the process. I do not know if you have seen a copy of that letter.

**Mr FLETCHER** — I do not think we have.

**Mr O'BRIEN** — I will just take you to it, because the issues are in a sense matters that you will be aware of. Under the heading 'Cost of administering the new scheme in comparison to the cost of the previous state system and further insight as to where improvements could be made to transparency and accountability', the college recommends or makes the point:

> The transition to the national registration scheme has been accompanied by a significant increase in registration fees, despite the expectation that the amalgamation of the state and territory medical boards would lead to operational efficiency gains and cost reductions.

Just in relation to one example — and it is an important example for the reasons said by the Chair, Mrs Millar and you, Dr Flynn — the loss of service in relation to the former health practitioners program is an example of a loss of service, yet we have had increases in fees sometimes in the order of 41 per cent for all chiropractic in the first year, medical 52 per cent, physiotherapy 72.3 per cent. They have been documented. What do you say to the general question: are health practitioners getting value for money as a result of the transition to the national scheme?

**Dr FLYNN** — If I could start with that first. First of all, the scheme is not here for practitioners; the scheme is here for the community. There are a number of checks on registration that were not there before: criminal history checks, more rigorous identity checking, more rigourous checking at all sorts of levels which enhance public protection. The national online register enhances public protection. In fact the services you are referring to have not been lost. The health services are still continuing. The question was about their future, and I have said that for medicine they are assured.

We do not have a comparator about what costs would be now if the scheme had continued, so it is true that for some professions, including medicine, the fee is 50 per cent dearer, and that is comparable across other jurisdictions. As I said, it is not actually here for the profession, it is here for public protection, and the scheme has to be resourced to do what it has to do. As the medical board we are responsible for overseeing notifications about medical practitioners, and we have to require of AHPRA a standard of service delivery that requires resourcing. It is not sufficient for us to say, 'We can't put the fee up, therefore we can't regulate properly'. We have to charge the fees that are needed.

I believe that the efficiencies in the scheme are only now starting to be drawn out of the national scheme. The implementation period has been acknowledged as being rocky, but that is one of the reasons that the medical board is able to commit to ongoing funding of the health program around Australia, so that in other jurisdictions much more than it will be here, there will be no increase to the medical registration fee beyond CPI.

**Mr O'BRIEN** — That is after we have got this initial increase?

**Dr FLYNN** — Yes.

**Mr O'BRIEN** — I was going to ask you that as my second question, and you have answered that. I appreciate your answer as to what this means for the protection of the community beyond health practitioners. One of the key issues we have — for example, we can see it by microcosm in that Dr Obi case in relation to

Stawell hospital, which has been documented and for which submissions were received — is that there is a tension between the provision of medical services, particularly in regional areas where they are scarce, and a delay in notification, which can in fact result in either an unnecessary complication or a withdrawal of services. With the loss of provision of course there is less exposure to the public of practitioners.

I would like you to put that to the test. On behalf of the community, one of the ways that we would like to put that to the test is by seeking some greater transparency, because it may be that the case put to you or put against you results in an increased bureaucracy. The 1500 meetings a year, if you like, have resulted in a slowing down of the system and not an increase in protection of the community. We as legislators need to get to the bottom of that. Given some admissions about problems with notification, would you accept, particularly in the initial phase, that there has been an increase in the efficiency of the bureaucracy as a result of this transition, which you are now maybe working through, but which does exist?

**Dr FLYNN** — In terms of the Victorian Board of the Medical Board of Australia, the meeting schedule now is much the same as the meeting schedule was of the Medical Practitioners Board of Victoria prior to transition, but we have added a layer of national board meetings, with the national board meeting once a month. All those meetings play out across the professions. There is an extra layer, and yet that brings with it a lot of increases in scale, an increase in sustainability and, looking at the policy issues, an increase in intellectual capital. It means that a lot of the differences in standards that existed before from state to state do not exist, and that if we are debating 'What should be the registration standard for an area of needs specialist who has come into the country?', that is one set of policy considerations that is put into a policy applied across the country. There are some efficiencies in that.

**Mr O'BRIEN** — And that is a tension.

**Dr FLYNN** — It is.

**Mr O'BRIEN** — Because whatever standards are set for service delivery in a service delivery model you would basically accept the health system as a state-based system. Then perhaps to pick up your phrase, Mr Fletcher, that in a sense AHPRA's role is with administration of this system. It is ironic because the very reason provided to AHPRA in relation to the three-month delay that occurred in the notification of Dr Obi's situation was administrative oversight. That could be lots of things — for example, are you able to tell us what the administrative oversight was in that instance? Was it a file sitting on a desk? A failure to refer? Are you able to tell us what that was?

**Mr MULLALY** — I can provide an answer to that. As far as conditions are placed on a practitioner's registration, at any one time we have just under 500 with conditions. This is the only recorded instance that this has occurred, and we have gone back into our files right from the start. It is regrettable. It was just an oversight. Somebody did not send a letter, did not type it or did not have cause for it to be produced by the system. It was not discovered until some 13 weeks later, and at that stage we sent it. At the time we discovered that, we apologised the next day to Stawell Regional Health — —

**Mr O'BRIEN** — Can I just pause there. At that time did you provide any explanation to the community, as opposed to the health centre, as to the delay and the reasons for it?

**Mr MULLALY** — We are obliged under the national law to inform the employer. I am not sure about whether AHPRA or the boards have a role to provide that information to the people. In fact it is probably privately protected — —

**Mr O'BRIEN** — I just want to break it down because of the time. When you say 'that information', in this instance we are talking about the reasons for the administrative oversight at AHPRA, which it has admitted. I know there have been legal issues around this thing, and I am not asking you to comment on that. The bit I am wishing to draw out for the transparency of AHPRA is the decisions about notification to the public of the error that AHPRA now admits to this inquiry — I think for the first time publicly — that there had been administrative oversight.

**Mr MULLALY** — The conditions were placed on the public record immediately.

**Mr FLETCHER** — The issue here was an issue of oversight in formally writing to the employer about the conditions. The conditions were on the public register, where they are accessible to the public.

**Mr MULLALY** — Yes, that is right, and that occurred immediately — —

**Mr O'BRIEN** — There are a whole lot of issues around Dr Obi's notification and the behaviour of the board. I do not wish to explore that. I am looking at AHPRA's — —

**The CHAIR** — If we could just move on from that.

**Mr O'BRIEN** — I know. I am being very careful to confine it to AHPRA's role and its accountability. There has not been, as I recall it, apart from the letter that has been provided to this inquiry, any statement of, firstly, admission of the AHPRA delay. That is correct, isn't it?

**Mr MULLALY** — We wrote to the health service apologising and admitting that we had examined why it had occurred and provided — —

**Mr O'BRIEN** — But you made a public statement at that time?

**The CHAIR** — I think Mr Mullaly is being quite clear that they do not have an obligation under the national law. Is that correct?

**Mr O'BRIEN** — He just confirmed that. That is fine. That would be his reason.

**Mr MULLALY** — I am not sure who we would write to, Mr O'Brien.

**Mr O'BRIEN** — I understand. I am just confirming there has been no public statement. I know you say it is a one-off at this stage from your investigations; I am happy to accept that at face value. But there was no public statement and therefore we then need to potentially examine some of the issues in relation to the levels of efficiency — —

**Mr ALLEN** — If I could just correct that, it was a published statement. To the extent that it is on our website, it is a published statement. There was no supplementary documentation circulated any more widely than that, but in terms of a definition of 'publication', it was published.

**Mr O'BRIEN** — About the administrative oversight?

**Mr ALLEN** — No, about the facts of the matter.

**Mr MULLALY** — The conditions were on the record.

**Mr O'BRIEN** — The conditions, yes. Thank you. I have clarified that. If I could just then go to some of the other accountability questions in relation to, for example, the number of staff employed, is that published? We have not been able to ascertain the number of staff employed by AHPRA.

**Mr FLETCHER** — What would you like to know?

**Mr O'BRIEN** — How many staff are employed and what is the total cost, at least in relation to the Victorian operations of AHPRA?

**The CHAIR** — Are you asking about the Victorian operations?

**Mr FLETCHER** — Are you asking about Victoria or nationally?

**Mr O'BRIEN** — However you can break it down.

**Mr FLETCHER** — At this stage we have just over 750 full-time equivalent staff across Australia, of which 145 full-time equivalent staff are based in our Victorian state office.

**Mr O'BRIEN** — Is this material reported publicly?

**Mr FLETCHER** — We have previously reported staffing numbers in our annual report. We did not do it this year, but there is no reason for it not to be publicly reported.

**Mr O'BRIEN** — What you said earlier was that you were trying to provide more information, and that is obviously a big question of accountability.

**Mr FLETCHER** — Yes. If there is additional information that you would like about our staffing, we understand that and are happy to provide that to you.

**Mr O'BRIEN** — Without being too clever, what are reasons behind it not being put in the annual report this year?

**Mr FLETCHER** — There was no reason. Essentially our major focus in the annual report this year has been on the data about our regulatory functions. As I said earlier, we have five times more tables in that area, so that has been the major focus.

**Mr O'BRIEN** — One of the other matters that was previously reported on was that there were almost 1500 meetings of national, state and territory boards. However, I do not believe the meetings for 2012–13 are recorded in the annual reports.

**Mr FLETCHER** — And what that reflects is that we regulate 14 professions across every jurisdiction in Australia. There are now close to 600 000 registered health practitioners. Of course it is the boards and the committees, as we have said, that make the decisions about practitioners. If they are not meeting, decisions do not get made, so it is obviously important that they meet regularly because that is an important part of the timeliness of our processes.

**Mr O'BRIEN** — That may be a reason for the number of meetings. We are seeking to examine the structure in this inquiry. However, what is the reason the number was not reported in the annual reports, if there is one?

**Mr FLETCHER** — On balance I think we did not think it was a particularly helpful number.

**Mr O'BRIEN** — It is an unhelpful number.

**Mr FLETCHER** — As you say, is it a high number; is it a low number; is it right or wrong? As I said, this year we have very much focused on trying to provide as much data as we can about our regulatory performance in terms of notifications, registrations and core regulatory functions.

**Mr O'BRIEN** — But if you accept that some of the practitioners who form an important part of the health services have concerns about the levels of bureaucracy and the delays that have been caused, wouldn't the number of meetings, if it has been raised with us, be another matter that should be publicly reported?

**Mr FLETCHER** — There is no problem with us doing it, but I do not think the number of meetings is a measure of our bureaucracy; I think the number of meetings is about —

**Mr O'BRIEN** — The structure.

**Mr FLETCHER** — boards and committees making decisions about practitioners, in the main, to make sure that registration and notification decisions are made. It is not AHPRA that makes these decisions. We support the boards and committees in this work and we need them to meet — —

**Mr O'BRIEN** — I fully accept what you have said when you say that it is not just AHPRA that is involved in a number of these decisions; it is all the other boards and it is a very complicated— —

**Mr FLETCHER** — We do not make these decisions; it is the boards and committees who make them.

**Mr O'BRIEN** — I understand. But we as members of Parliament in conducting this inquiry need to ask these questions for the public. It has been described, in the first instance, as a multiheaded hydra because of its complexity in the retention of the state. The partial national system is said to be very complex, and we are seeking to explore that. Some other matters that have been brought to our attention are the investments. I think there is $81 million —

**Mr FLETCHER** — There is not $81 million.

**The CHAIR** — Would you like to correct that figure if it is not $81 million?

**Mr O'BRIEN** — in the number of investments for a total at 30 June 2013.

**Mr FLETCHER** — The investment; I thought you were talking about the reserves.

**Mr O'BRIEN** — Yes, that is correct. You made me nervous when you were shaking your head as I was saying it.

**Mr FLETCHER** — Are you talking about the reserves?

**Mr O'BRIEN** — Yes.

**The CHAIR** — Could you please get to your question, Mr O'Brien?

**Mr O'BRIEN** — Regarding the total of investments, in the submissions made to us, having investments may not be a problem, but the level of investments in proportion to the number of fees may be said to be slightly excessive.

**Dr FLYNN** — Mr O'Brien, we collect all our revenue in one hit in the renewal period. We invest it across the 12 months in cycles to enable us to pay the bills across the year. That is what those investments are. It is separate to the reserves.

**Mr FLETCHER** — It is essentially prepaid registration income because we have three: there is a renewal date for all medical practitioners, all the nurses and midwives and then all the other professions. So that is what that reflects. We have a very conservative investment policy. It is on our website. It is overseen by our audit and risk committee, and we essentially only invest with the four big banks.

**Mr O'BRIEN** — I will just come to two more questions if I could, Chair.

**The CHAIR** — Very quickly, because I need to move on to other members.

**Mr O'BRIEN** — Thank you, Chair. There was also concern about the number of legal costs, particularly external legal costs. These are matters if you are reporting that are often required of parliamentary bodies like PAEC. I sit on PAEC, and a common question that is asked is around the number of consultants and the total amount of legal costs. Are they matters on which you are prepared to provide greater transparency? It is the decisions; it is not actually the legal matters but the quantum of costs and the proportionality of that.

**Mr FLETCHER** — Our external legal costs primarily reflect our costs in relation to notifications. We have moved to a set of panel arrangements where we went through a national procurement. We have contracts with providers around the country for which we are very focused not only on the quality of the legal advice but also the cost.

**Ms HARTLAND** — I was rung by a friend this morning who is a doctor. One of the things that has been raised with him by a number of other doctors is: if someone in Victoria is dodgy and they move to New South Wales, given New South Wales has a separate reporting system now, does that mean that person would be able to practice in New South Wales, or does the national system make sure that does not happen?

**Mr FLETCHER** — The national system makes sure that does not happen. Any outcome from the New South Wales system comes into the national register, and it is the national register that describes the restriction on practice.

**Ms HARTLAND** — It will pick up all of those? That is great, thanks.

**Ms MIKAKOS** — I want to come to the issue of overseas-trained doctors if I may. Can you comment on the supervision of limited registration overseas doctors, including supervisor ratios in comparison with locally trained doctors? It has been suggested that we have a two-tiered system where we have overseas-trained doctors who are receiving an inadequate level of training because of a supervisor-to-trainee ratio of 1 to 4 or more. Could you comment on that?

**Dr FLYNN** — That is my area to respond to. The medical board is responsible for setting the supervision arrangements. We have a set of supervision guidelines, and the registration committee in each state looking at each individual applicant determines what level of supervision applies. As Mr O'Brien was referring to before, it is always a matter of balancing in terms of provision of services to the community and protection of the public. Each individual overseas-trained doctor is assessed through a process which often involves input from their specialist college. The board then makes an assessment through its registration committee about whether the overseas doctor is fit for a particular job — that is, to do a particular job under a particular set of supervision arrangements that apply in that practice, which may be a hospital, general practice or specialist practice.

It is not comparable to the system of vocational training for locally trained doctors. When the overseas doctors come in we are talking mostly about doctors who are already trained. The supervision for local graduates is about people who are in the course of their training.

**Ms MIKAKOS** — I have a further question, if I may, relating to revalidation. Dr Flynn, perhaps you might be able to assist with this as well. I understand that in November last year the Medical Board of Australia announced its intention to open discussions with the medical profession around the need for revalidation powers. Under the old legislation there was an ability to seek a practitioner to in essence make a case for continuing competence on renewal of registration, particularly where there was a lack of recent practice or a change in the type of practice involved. I understand that there are no similar powers under the national law.

**Dr FLYNN** — That is not correct. I will correct that, if I may. In the scheme of registration standards that we have, which is the greater public protection, the board has set a standard about continuing professional development that all medical practitioners have to meet and attest to having met every time they renew their registration. There is also a standard for recency of practice, which is about not having changed scope of practice since the last time they renewed. There was no standard for recency of practice in the old system.

The board, being aware of what is happening in international jurisdictions where the term 'revalidation' is being used for something which is beyond current continuing professional development, is asking the profession and the community what we should be looking for in doctors in Australia into the future. Is it within the framework of the continuing professional development requirements with recency of practice, or is it something beyond that where people have to actually demonstrate that they are competent and professional rather than that they have attended or participated in certain processes? That is an open discussion, whether it comes under an umbrella called 'continuing professional development' or whether in the fullness of time we seek legislative power through consultation, including with health ministers, to require a more formal process on a 3, 5 or 10-year cycle of demonstrating meeting a standard is the question we are discussing.

**Ms MIKAKOS** — Thank you. In my previous profession I was a lawyer, and this issue of continued professional development was a very vexed issue. Where do you think this might end up in terms of — —

**Dr FLYNN** — What it is doing already is focusing on what we know about doctors who are at risk of poor performance. We know things about their practice setting, how long since they qualified and the number of hours they are working — too many or too few. We are currently looking at the clinical governance arrangements that apply within our health services, the way in which they ensure that doctors continue to be competent and whether there are groups of people who are missing out through those services.

I am a general practitioner. I work in a very high-quality practice, but it is now some time since I graduated. I do not work as many clinical hours as I used to, so I am at some risk of not performing as well as the community might expect. If I look at it with my regulatory hat on, what is there to make sure that I as a GP am doing okay? I do my continuing professional development, but is that enough? As I said, that is the question we are asking.

In the meantime the colleges are looking at their continuing professional development programs and asking, 'Are they rigorous enough? Are we able to say that people who've met the programs we deliver and that the board prescribes are at an adequate standard?'. I think this conversation will take somewhere between 3 and 10 years for us to get clarity about where we think the gaps might be and whether there is a role for the board.

**Mrs PEULICH** — I have two questions. One question is: how are notifiers informed of the complaints process, the time lines, the appeals available to them and so forth?

**Mr MULLALY** — There is an extensive and new set of information on the AHPRA website providing information for notifiers and for practitioners about whom a notification might have been made. In that, we are told, is as much information as might be required to inform people as to how to go about making a notification, what will happen, the professional conduct and standards issues that the boards will be involved in and interested in, the risk assessment, the immediate action potentials, the length of time for which an investigation might happen, the frequency of communication between notifiers and AHPRA on behalf of the boards and so on.

**Mrs PEULICH** — And the appeals process?

**Mr MULLALY** — And the appeals process, yes.

**Mrs PEULICH** — Is that information consistent with information that is made available to complainants who may be approaching the health services commissioner or the ombudsman?

**Mr FLETCHER** — There is an ombudsman for the national scheme that is unique to the work of AHPRA and the boards in relation to notifications. As I said earlier, if you have a concern about the process of how we have dealt with something, then the ombudsman can potentially have a look at that.

It is probably worth adding — and this goes back to the discussion that we had before about our community reference group — that one of the areas the reference group has a very big interest in is notifications. For example, one of the areas we are working with them on at the moment is to review the written material that we have developed for notifiers and to look at how we can make sure that it is appropriately targeted and addressing the information needs of notifiers.

**Mrs PEULICH** — In relation to information that is on the website, when did it go up?

**Mr FLETCHER** — I would have to check the exact date, but it has been there for around six months.

**Mr MULLALY** — Yes, six months.

**Mr FLETCHER** — I think we have included in the additional information some examples of the information we have developed. One of the things — —

**Mrs PEULICH** — How often does the community reference group meet?

**Mr FLETCHER** — The community reference group is meeting I think every couple of months, so they have met three or four times face to face. They are also having teleconferences. I know they have a meeting next week — in fact, it is this week — with the Health Issues Centre about the work that we talked about earlier.

**Mr MULLALY** — Mrs Peulich, you have alluded to the health services commissioner; we meet with them every week — —

**Mrs PEULICH** — I understand that.

**Mr MULLALY** — And they will provide that kind of information to potential notifiers.

**Mrs PEULICH** — Fragmentation and lack of awareness of the process are always challenges, no matter which sector we are looking at. It seems to me that there are number of entry points, and there is enormous confusion about the roles and how they interface with one another. I think a simplified document that passes the grade 8 journalism test is probably something that is needed for the public.

**Mr FLETCHER** — I think the work of the community reference group is really helping us to do that.

**Mrs PEULICH** — After three years of it being in existence!

Last question: in terms of governance, what is the desirable degree of separation between the role of accrediting medical professionals and establishing the sorts of PD schemes that are appropriate, and the investigation of complaints? Is that desirable degree of separation reflected in the current scheme?

**Dr FLYNN** — If I understand your question — or rather, let me try to answer your question. The accreditation body for medicine is the Australian Medical Council. It accredits undergraduate medical education and colleges that provide postgraduate education, including — —

**Mrs PEULICH** — And registration?

**Dr FLYNN** — It accredits education programs, and then the board decides whether to approve that accredited program for the purposes of registration. The board sets the standard for continuing professional development, which involves essentially for specialists people doing what their college requires, and the AMC then accredits that. All of that activity is completely separate from investigation of notifications. For starters, those policy roles in medicine are done by the national board; the investigation matters are conducted at the state level by the state board — that is, the decision about investigations.

**Mrs PEULICH** — Is there an appropriate degree of separation? Do you feel that is reflected adequately in the system?

**Dr FLYNN** — I do not think there is any issue there.

**Mr O'BRIEN** — I just wanted to finish one of the requests from the Royal Australian College of General Practitioners. The third dot point that was raised was:

> The RACGP believes that AHPRA should provide each of the health professions with a detailed breakdown of their registration costs, including the costs for registration administration, complaints handling, staffing, IT et cetera. This is particularly important for any fee increases.

Are you prepared to provide that?

**Mr FLETCHER** — We provide a lot of that information already. I will take medicine as an example. We have a health profession agreement with each of the professions in the scheme, and that, among other things, sets out the budget, the fees and the budget for the board and how that budget is being spent. In the annual report I can refer you to the audited statements; on page 193 we provide a breakdown by board of the income for each board, and the expenses and the net result for the year. We provide information on the proportional share of AHPRA costs that each board pays, and we also provide information on the equity or reserve position of each board. A lot of that information is already there.

The wider point I would like to make, and perhaps it picks up on the point you made earlier, is that if there is a view that there is additional information that you think would be helpful for us to include in the annual report, we would welcome hearing that and having that feedback. We would certainly look at how we could integrate that into future annual reports.

**Mr O'BRIEN** — The particular concerns were in relation to the number of meetings et cetera and the internal administration costs. In the sense of following the dollar for efficiency, which is a particular auditing technique, if unnecessary costs are discovered, it can mean that there are more systemic problems in the way that the thing is structured. That is not to say that it is anybody's fault, but there may be too many reporting requirements going the wrong way or perhaps there is not efficiency in decision making. That is what we are trying to get to the bottom of, if you could help us with that.

**Mr FLETCHER** — We would welcome any feedback from the committee about areas where it thinks we could report more in the annual report.

**Mr O'BRIEN** — My last matter follows on from Ms Hartland's questions, and it is in a sense an important philosophical question. I want to preface it by saying that these are questions that have been provided to us and that obviously protection of the community is extremely important. I do not mean to be disrespectful in my search for this information; it is stuff we need.

My question relates to when there is a problem in the provision of medical services to the public, particularly in notifications, for example. There have been some arguments put to us that in some respects it is better to retain a state-based system. It has been argued this is advantageous because — to use a medical term — it quarantines the problem in the state that has got a problem. I am referring to the regulators and to AHPRA. If there is a problem there, it is better if it is isolated rather than having it potentially occur simultaneously across the

country. A corollary to this would be the pink batts rollout, where an efficiency problem occurred at a national level. Is that something that with state delivery we ought consider? Should we look at a more nimble or New South Wales style notification system to ensure that there is that quarantine?

**Mr FLETCHER** — If I could perhaps restate some of what I said in my opening comments, I think we believe that there is a viable model of medical regulation in Victoria that is working well. It is not perfect. We recognise that there are areas for improvement, there are steps we are taking to improve that and we welcome the feedback from this committee about other areas of improvement. Fundamentally there are local practitioners and local committee members making every decision about every medical practitioner in this state where there is a concern about their health, their performance or their conduct in a relationship with the health services commissioner and ultimately in an interaction with VCAT, which obviously makes the decisions about the cancellation of registration in very serious cases. Fundamentally it is a state-based system — —

**Mr O'BRIEN** — Just on the serious cases — —

**The CHAIR** — Mr O'Brien, I want Mr Fletcher to finish, please, because we need to conclude.

**Mr FLETCHER** — I think that sits, though, within a context of national standards, national registration and national mobility, which are all enormous workforce benefits of this scheme. Our view would be that in many ways you have many elements of that already in the model with the benefits of a national model. As we said, I think there are steps that could be taken if the committee felt that was needed to increase the accountability locally, and we welcome the feedback on that, but we fundamentally think that the model is working as a local decision-making model.

**Mr O'BRIEN** — Just cutting in, I will raise one aspect that is important at this point; it is critical. In this area, the decisions are very complex and require expertise, and perhaps there is no better example of that than the Professor Dewan case, which I thank you for your response on, but there is the whole question of peer-to-peer review, when you are dealing with very narrow expertise and genuine opinions as to the best techniques, the best way to regulate and the best forensic operational decisions. It can be matters where great minds can differ, but that is a very complex area of regulation, and that is why we really need to think about the best and most nimble system to deal with problems when they arise. Do you understand that aspect of it? I am sure you do. Could you help us with your thoughts on that?

**The CHAIR** — I think what you are asking is: should those issues remain in a local jurisdiction, and are they being dealt with at a national level?

**Mr FLETCHER** — Again, I will not comment on individual cases, but if I go to the wider point, if there is a view that there are elements of the model that need to be changed, our view would be that that is appropriately looked at in the context of the three-year review, where there is an opportunity to look holistically at the legislation and the model as it has worked, and if there is a view, as I said, that it needs finetuning, let that review be the place for that to be looked at. That is where those sorts of questions would sit.

**Mr MULLALY** — I will also add that in the national scheme, if we needed to get a specialist auditor, reviewer or supervisor, we were not able to do that within Victoria necessarily. The national scheme opens that up to getting experts, including expert practitioners, expert advice and expert supervision, right around the country, and that is a benefit of the system.

**Mr O'BRIEN** — I tend to differ on that, but I will not ask another question.

**Mrs PEULICH** — I have two follow-up questions to Mr O'Brien's previous question, if I may, Chair. Do you have views of what additional information could and should be regularly included in your annual report? Also, I am not sure whether we actually have a copy of your new KPIs.

**Mr FLETCHER** — We did include them in the additional update information, but I am happy to — —

**Dr FLYNN** — While that is being sought, I will just make a comment about what performance information should be sought. I think it is really important to focus on performance rather than staff numbers or numbers of meetings. It is like running a health service. It is about how many people get treated, not how many staff it takes to treat them. 'What does it cost?' is a fair question when counting numbers. A meeting might be 5 minutes or it

might be a full day. I think a table of the number of meetings is meaningless. We very much want to report things that indicate our performance and indicate whether we are financially responsible, but not necessarily data that hangs out there that does not have any meaning.

**Ms MIKAKOS** — The KPIs are critical.

**Mr FLETCHER** — We provided additional information in the big update information, but we can obviously provide more if you wish.

**The CHAIR** — I think Mrs Peulich has that now. She is reading that information.

**Mrs PEULICH** — I have that now. Is that comprehensive?

**Mr FLETCHER** — No, there was more than that as well in the big package of information we sent out about a week ago.

**The CHAIR** — I have one final question, and it is directed to Dr Flynn. In your message in the annual report, you posed a question and spoke about a number of issues. You looked at two particular areas that you have considered: the revalidation, which Ms Mikakos has addressed; and the other one is to look at whether doctors who are on the register remain fit and competent to practise. Finally, in your concluding remarks you say, 'Are we achieving our primary purpose of public protection?'. I would like to ask: are you?

**Dr FLYNN** — I believe we are doing a better job of that now than we have ever done. I think there are always challenges in this businesses, but if you speak to people on the Victorian board and people on boards around the country, the fact that we are part of a national scheme means that we can discuss the hard issues together. We have much better processes than we had. I believe it is better than it was, and I believe that the public scrutiny we have is helpful, but ultimately on the question of accountability every board member feels accountable to the community for the decisions they make. We have that critical job of balancing risk to the public with the provision of health services, and we seriously reflect on where the thresholds are for that and what the right decision is in the interests of the committee for the matters they have before them.

**The CHAIR** — Thank you. That concludes our questions, so on behalf of the committee I thank you all very much indeed for your attendance this evening and your time. We very much appreciate the time you have given to us, and your evidence has been most helpful.

**Committee adjourned.**