HEALTH SERVICES COMMISSIONER
Human Rights Commission

21 November 2008

Ms Bronwyn Nardi
Chair, Practitioner Regulation Subcommittee
Level 12, 120 Spencer Street
MELBOURNE VIC 3000

Dear Ms Nardi

Thank you for the opportunity to provide a submission on the consultation paper issued by the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee on 7 October 2008 in relation to *Proposed arrangements for handling complaints and dealing with performance, health and conduct matters* under the national registration and accreditation scheme.

I have had the benefit of reading the submissions of a number of my colleagues and endorse their comments in relation to the risks associated with reverting to a model of self regulation by health professionals. Prior to the establishment of independent health complaints commissioners, registration boards regulated their own professions and the shortcomings of that model have been well documented. I need not repeat that history in this submission.

The Human Rights Commission of the Australian Capital Territory promotes the human rights and welfare of people living in the ACT and provides an independent, fair and accessible one-stop shop for complaints of unlawful discrimination, and complaints regarding health services, services for older people, disability services and services for children and young people.

The Health Services Commissioner has a broad range of functions under the *Human Rights Commission Act 2005*, including legislative responsibility for considering complaints and reports about the providers of health services in the ACT, regardless of the source of those complaints. The office was not established simply to consider consumer complaints or to have a narrow role focussed primarily on conducting conciliations.

My office investigates complaints made directly to it, as well as many matters that originate from reports to health profession boards. These cover a range of matters from minor disputes to significant breaches of standards of practice with long-lasting adverse outcomes. The legislative regime in the ACT requires the boards to provide the Commission with all reports made to them about health professionals.

The Commission has extensive powers to require the production of information and to compel people to appear before it. In considering complaints the Commission regularly seeks independent opinions on clinical issues and issues around professional competence. These are generally sought from interstate so that there is no conflict of interest or perception of bias, as would inevitably be the case in such a small jurisdiction as the ACT if expert opinions were only sourced locally. If the Commission considers that a health professional may have contravened the required standard of practice, the Commission must jointly consider with the relevant board what course of action is to be taken in relation to that health professional. In the event of disagreement, the strongest view prevails.

In the event that a health professional is referred to a professional standards panel, the Commission is able to give evidence and also has a right to be present at a panel hearing, even if not giving evidence. Within 28 days after a panel hearing, the panel must report back to the Commission.

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The legislation also provides that the Commission is not prevented from considering a matter when it has been referred to a board. Further, Commissioners have the power to publish reports on matters of public interest.

These provisions ensure that the Commission is able to act impartially and independently. More importantly, they provide the community with reassurance that matters are investigated without bias and that there are appropriate checks and balances in relation to the boards' management of processes when concerns have been raised about the conduct of health professionals.

These outcomes would not be achieved under the model proposed in the consultation paper. The principles outlined in paragraph 1.5 of the paper would not be met.

The paper assumes that health complaints commissioners' only role is to resolve complaints from consumers, while "the national regulatory scheme is designed to protect the public as distinct from resolution of complaints" (p. 11). Because of this misunderstanding of the role of health complaints commissioners, the model that flows from this thinking is fundamentally flawed.

The paper provides no evidence for why health complaints commissioners should be marginalised into the role of considering only consumer complaints and removed from the independent and impartial watchdog role for which they were established.

The proposed model provides that if boards receive notifications about professionals they will determine how to deal with those matters. Boards will only need to consult with health complaints commissioners if the notification comes from a consumer. If the notification gives rise to questions about professional competence or misconduct, health complaints commissioners would be required to relinquish the matter and refer it to the board. Boards would conduct their own investigations into matters and would decide whether or not to take further action in relation to a health professional. Transparency is immediately lost.

The paper fails to appreciate the benefits of independent oversight both for the public and for health professionals themselves. If independent arms length investigation, transparent processes, and checks and balances are built into the scheme, there is less likelihood that boards will face the criticisms that occurred in the past. Under the self regulation model "there was a perception that professionals were simply protecting each other's backs, and that their strong impulse to understand their colleagues' situations accounted for a reluctance to take disciplinary actions against not only the erring, but also negligent and incompetent practitioners."[1] Boards should not be set up to again be criticised in such a way.

While there are a range of different models applying throughout the country, there are a number of elements that I consider essential in any new regulatory model – these are sharing of information between boards and health complaints commissioners; joint consideration of complaints and reports, regardless of their origin; independent and impartial investigation of matters by health complaints commissioners, with appropriately strong powers; and the power to rest with commissioners to make final decisions about action to be taken in relation to health professionals who fail to meet required standards of service provision.

Yours sincerely

Mary Durkin

Health Services Commissioner

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1 Medicine Called to Account: Health Complaints Mechanisms in Australasia, Edited David Thomas, Australian Studies in Health Service Administration, No 93, University of New South Wales, 2002, p3.