COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: National registration and accreditation scheme for doctors and other health workers

TUESDAY, 14 JULY 2009

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Tuesday, 14 July 2009

Members: Senator Moore *(Chair)*, Senator Siewert *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Boyce, Carol Brown, Furner, Humphries, Moore and Williams

Terms of reference for the inquiry:

To inquire into and report on:

The design of the Federal Government's national registration and accreditation scheme for doctors and other health workers, including:

a. the impact of the scheme on state and territory health services;

b. the impact of the scheme on patient care and safety;

c. the effect of the scheme on standards of training and qualification of relevant health professionals;

d. how the scheme will affect complaints management and disciplinary processes within particular professional streams;

e. the appropriate role, if any, in the scheme for state and territory registration boards; and

f. alternative models for implementation of the scheme.

WITNESSES

Committee met at 9.02 am

DODD, Mr Peter, Solicitor, Health Policy and Advocacy, Public Interest Advocacy Centre

CHAIR (Senator Moore)—Good morning.

Mr Dodd—Good morning.

CHAIR—Thank you so much for your patience. We are now moving into our consideration of the inquiry into the national registration and accreditation scheme for doctors and other health workers. I know you have information on parliamentary privilege and the protection of witnesses. We have your submission; thank you very much. You may make an opening statement, and then we will go to questions. Just to check: was your submission presented before or after bill B was made public?

Mr Dodd—Certainly before.

CHAIR—I thought it was. There could well be some changes, so please highlight those for us as well. You have now seen bill B?

Mr Dodd—Yes, I have.

CHAIR—The floor is yours.

Mr Dodd—Thank you. As an introduction, PIAC is an independent, non-profit law and policy organisation that seeks to promote a just and democratic society by making strategic interventions on public issues. PIAC certainly has a history in relation to patient safety and health complaints that goes right back to the 1990s in New South Wales. PIAC was a leading force in the changes that led to the New South Wales Health Care Complaints Commission. PIAC was active in both litigation and law reform around the issues that surrounded the Chelmsford royal commission. We have a long history of interest in these issues.

We welcome the changes that have occurred in what you call bill B. In the submission that PIAC made about the initial discussion paper, PIAC was quite concerned about some of the aspects of that. The submission is attached to the submission to your inquiry. PIAC set out a number of principles that we thought should be reflected in any healthcare complaints legislation. I must say that we welcome the changes that have been made in the bill to reflect some of those principles. In terms of New South Wales consumers, we believe that the new arrangements will better maintain their existing protection. But we do have concerns beyond the boundaries of New South Wales. We still maintain that some of those principles are not reflected in the current draft bill. I had not intended to go into those objections today, because PIAC intends to make a submission on those matters both to the government and to your committee in the near future, but I am certainly able to answer questions on our preliminary view in terms of that legislation.

PIAC did raise some other issues in our submission, however. The other issue that we took the opportunity to put forward a position on was that we still maintain the view that there should be one, national registration board. That was the recommendation originally from the Productivity

Commission, and the reasons for that are set out in our submission. The public, the government and the parliament should bear in mind that that was the original impetus for reform in this area, and somehow that has been lost, somehow the arguments that are in that report have been lost in the subsequent debate. Very briefly, PIAC is a strong supporter of the Charter of Healthcare Rights and think that any reform in this area should be included in the charter and any national regime of health regulation. This can be done. If you look at the New Zealand model or even, closer to home, at the ACT legislation, they successfully marry the enforcement of healthcare rights alongside the more traditional peer review model in terms of regulation of health professionals.

The last point—and a very important point—that PIAC makes in our submission is that we are concerned about the lack of consultation in the period leading to bill B. Our concern is that there will not be appropriate public consultation surrounding bill B. I had contact with the NRAIP yesterday, and they gave me the impression that when the consultation period for bill B closes after the 17th, which is the end of this week, there will be a very short time indeed before the next step occurs and draft legislation is produced. This is of great concern to PIAC. I think, contrary to what has been said in government circles, there has been very little public consultation up to this date.

In October last year I attended in Sydney an Australia-wide consultation on the paper that was submitted at that time. People were there from all over Australia. There were very few representatives from consumer groups. They were vastly outnumbered at that meeting by representatives of medical organisations and representative organisations. That is all right and proper, but PIAC is very concerned about the lack of opportunity for consumer groups to comment on the draft bill. Almost all of the consultation has been done at a national level.

I was at a meeting recently of consumer groups and I understand that some consultation has taken place in some states. That consultation was, I understand, initiated by the state governments concerned. I am not aware of any consultation initiated at the national level or by COAG bureaucracy. I think that there definitely is a need for further consultation. There are a lot of very significant changes in bill B that affect consumers and I think that there should be opportunity given to consumers in the states and from state based organisations to make comments about that. I do appreciate that in New South Wales there will probably be a different regime, but the state government here also needs to be consulted that.

I will make this my final comment: we have had over 100 years of state based regulation of health professionals and I cannot see why we cannot spend a little bit more time getting it right in relation to the national regulation scheme. I will end my comments there.

Senator HUMPHRIES—Thanks for the submission and your comments this morning. I know it is never easy to give evidence over a telephone. You have argued for that one national board model.

Mr Dodd—Yes.

Senator HUMPHRIES—To be frank, the difficulty that we face in this committee is that we have had a large number of submissions from a lot of witnesses in the inquiry and I think I can say without exception that every one of those other witnesses and probably almost all the

submissions have argued for the strict separation of the professions into their own particular board. They have argued passionately for the professional bodies, such as the colleges and professional associations, to be the custodians and gatekeepers of quality and standards within their own particular occupational groups. Can you give us a potted, one-minute rebuttal to that argument that suggests that standards would be better cared for or maintained by a single national board?

Mr Dodd—I appreciate that a lot of those submissions would come from the professional bodies themselves, so I guess you could say that is a little bit self-serving. And that is not surprising. I wonder how many consumer organisations put up those arguments. The second thing is that I do not think, to comment on your specific comment, that one national registration board would affect the ability of the colleges to set standards. I do not think the Productivity Commission recommended the abolition of professional colleges in the medical profession. What it did argue was that one national registration board or authority would be able to better regulate the health profession in Australia in the future. The reasons for that are set out in the submission, and I think they are set out very clearly there.

Senator HUMPHRIES—Were we to recommend that, I think there would be pretty active opposition on the part of all of those professional groups. Do you think that would be a surmountable factor in the task of getting a better system of national health registration?

Mr Dodd—The Productivity Commission was not shy in setting out the power that those groups have and the power that those groups that are represented by those organisations have in setting back health care in Australia. A good example that is set out is the area of nurse practitioners. In Australia we do not have enough nurse practitioners, and the major reason for that has been the opposition of the medical profession—reflected not only in their power to influence government but also in their obvious influence over the state medical boards. We need nurse practitioners in Australia. Why don't we have them? It is because there is that resistance from the professions. If we had more nurse practitioners in Australia, we would be able to provide better health services, especially in rural and remote Australia where they really need these services.

Senator HUMPHRIES—I suppose the alternative to having these processes controlled by the professions is to have the processes controlled by governments or health departments within governments. The professions have argued that even the present model—which is less dangerous from their point of view than the previous versions of bill B—still provides a role for government effectively to press the professional groups to make some compromises in the operation of professional standards to allow for areas of need to be catered to—for example, providing the possibility that people without a full complement of training might be able to work in remote areas where there are shortages of particular occupational groups. The professional groups argue that they are the custodians of those standards and they will not compromise them lightly but governments would willingly give those standards away in order to get people working in those areas of underservicing. What is your take on that argument? Do you think that they have a point?

Mr Dodd—I do think that they have some point there. Looking at that draft bill, I think that PIAC will be making some comment about those provisions. We would be concerned about the potential diminution of standards in relation to those provisions, but that does not take away

from the argument that those debates and those concerns would be better dealt with by one national provider board. I think they are real concerns, and clearly these are not easy issues that have instant answers, but, nevertheless, I think that these issues should be looked at not on the basis of necessarily the interests of the profession but rather the interests of consumers. That is the issue. What is in the best interest of consumers? Certainly that one does provide a vexed question. You can argue that those consumers desperately need health care but, on the other hand, is it good for those consumers to potentially have a lesser standard of health care because some health professionals are allowed to practise when they are not normally allowed to practise?

Senator HUMPHRIES—You talk in your submission about the lack of public consultation—and I might say that you are not the first person to raise that issue with us. You make the point:

There has been unfortunately little reporting in the media about these issues. Consequently there is little public awareness of the significant effects on consumer rights that the proposed model in the Discussion Paper would have in some states and territories.

You mentioned that New South Wales is preserving its own independent health complaints commission structure. I understand that in the ACT its health complaints commissioner would still operate independently of this structure and would still take complaints about the operation of the health system generally, notwithstanding the structures being set up here. Do think that there are at this stage any serious effects on consumer rights in the present way that bill B appears to be modelled?

Mr Dodd—PIAC has a range of concerns about bill B. Do you want me to outline them?

Senator HUMPHRIES—Yes, please.

Mr Dodd—They will be developed in a later submission. These are not in any particular order. PIAC is concerned about the advertising provisions. They are relatively limited compared to some of the state legislation. PIAC is concerned about the lack of sanctions that apply against intimidation of complainants. In the submission that you have, which includes the original submission, PIAC was particularly concerned about the lack of openness about the panels that are suggested under the legislation. That has not changed. I have already mentioned our concern about the limited registration in areas of need. One of the particular concerns is that there is virtually no opportunity for consumers to seek review of the decisions of the national boards in the legislation. In New South Wales there is limited opportunity for consumers to seek an internal review of a decision, say, about an assessment or about an investigation. But, in this legislation, the only people who have the opportunity to seek a review are the health practitioners. There is no question that health practitioners should have every opportunity to seek reviews of the decisions—it affects their livelihood—but there also should be opportunity for consumers to seek review of decisions. The process needs to be open and there also needs to be an opportunity for consumers to fully put their views.

Senator HUMPHRIES—I have one more question. The national boards will all have consumer reps on them. I assume that this will be for the first time in the case of the registration processes applicable in some states. I imagine there are some states where there are not presently

consumer reps on those equivalent boards. Are you happy with the way in which the consumer representation arrangements are set up with respect to each of the boards?

Mr Dodd—You are asking me to put a PIAC view to something that we have not developed a final position of. I will speculate, though, if you will allow me. I will make one comment. I will correct you: they are not actually consumer reps on the board; they are community representatives.

Senator HUMPHRIES—Okay.

Mr Dodd—That is very different. If someone is representing the community—given that is what they are doing—they may have to take into account a whole range of things in representing someone from the community. If someone is a consumer rep, they may well be able to better focus on consumer issues. Yes, we obviously welcome consumer reps or community reps, but that is a start not the end of consumer participation in these issues. I think that the government should consider having consumer representatives as well as people on the boards who represent broader community interests.

Senator HUMPHRIES—Thank you very much, Mr Dodd.

Senator CAROL BROWN—I would like to get your understanding of and views on the role of the public interest assessor.

Mr Dodd—That is a very interesting question. That is probably the first question that I would ask in any public consultation, because I do not think the material that I have got so far actually answers the question: what is the role of the public interest assessor? It does seem to be similar to the role that the Health Care Complaints Commission plays in New South Wales in terms of the assessment of complaints. I think it is very unclear what the role is. As I referred to earlier, I took part in an Australia-wide discussion with other consumer groups and organisations. They were unclear about the role of the public interest assessor, and some of them had attended the state-initiated consultations. So I would say that it is very unclear. It is unclear how the public interest assessor will be funded, what sort of resources that organisation would have and how independent that organisation will be, given that they are still part of an infrastructure that has been built up around this national registration scheme.

Senator CAROL BROWN—If those concerns that you have just highlighted are answered, do you see a valuable role for the public interest assessor as separate from the boards?

Mr Dodd—In PIAC's original submission I think our key point was that there should be an independent body that assesses healthcare complaints, that investigates healthcare complaints and that prosecutes healthcare complaints. If the independent assessor meets that criteria, obviously it is a positive step. But, again, I reiterate: it is not clear how independent that independent assessor will be and it is also not clear how well resourced that independent assessor will be. So I cannot really fully answer your question until we get that information. But, yes, it is certainly an improvement on what was in the original discussion paper.

Senator CAROL BROWN—In your previous answers you have touched on the national board and the need for consumer representation. I just want your view on the make-up of the

advisory council. As you are probably aware, that is the council that is going to be appointed by the ministerial council.

Mr Dodd—PIAC has not come to a view on that. Could you just enlighten me about who is on the national advisory council?

Senator CAROL BROWN—According to the exposure draft or bill B, the advisory council consists of seven members that are appointed by the ministerial council. A person appointed is not a registered health professional and has not been registered as a health practitioner under the law for the last five years. And at least three of the other members of the advisory council are to be persons who have expertise in health or education and training.

Mr Dodd—That sounds like a consumer representative. Is that what you are saying? PIAC would certainly suggest that any advisory council should have one or more representatives representing the views of consumers.

Senator CAROL BROWN—Both at the national board level and at the advisory council level?

Mr Dodd—Yes. And there certainly would be people who would be suitable for appointment to that sort of body who would have experience in representing consumers.

Senator CAROL BROWN—Thank you, Mr Dodd.

Senator WILLIAMS—Senator Humphries covered most of the things that I am interested in. You said that you have some questions about bill B and the lack of sanctions. Can you expand on the lack of sanctions, please?

Mr Dodd—For complainants, in the New South Wales legislation it is an offence to intimidate someone who makes a complaint; it is an offence to harass someone who makes a complaint. I could not find anything in this legislation that has a similar effect. I might say that no-one has ever been charged under that part of the New South Wales legislation, but it provides a deterrent against people intimidating or harassing someone who complains. I have said some experience in the health complaints area. People are reluctant to complain because they fear intimidation. That is certainly not going to stop if you have a similar provision to the New South Wales provision, but at least it will consumers some comfort that if people do try to intimidate them that there is a penalty for that.

CHAIR—I think you have talked us out, Mr Dodd. Is there anything that we have not raised that you want to get on record? I know that you stopped your opening comments to allow us to ask questions. Were there any other issues that you wanted to put on record?

Mr Dodd—The important point is that we are very concerned about the lack of consultation. As I said, after a discussion that I had yesterday with the NRAIP, I am very concerned. They seemed to be suggesting that there was going to be a very short time between next Friday and when the legislation is going to be produced. This legislation needs a lot of public consultation. It affects people's lives in a big way and there should be public consultation. Clearly, today and your future deliberations will assist in providing public consultation, but really whoever is

drafting or promoting this legislation should be going out to the states and regional areas to try and sell it and give people information about it. As I said, there has not been a lot of information in the media about it, and I guess that is because it is not a sexy or sensational issue such as the issue of Dr Death or things like that. Nevertheless, we should be very careful before we introduce a national scheme. That does not mean that PIAC does not support a national scheme for the regulation of health professionals—we definitely support it. But we should be very careful about what sorts of provisions that we put in it, especially in relation to health complaints and patient safety.

CHAIR—I know that you spoke about this in answer to other questions from other senators, but I want to focus on the impact on the wider public. You focused on the health complaints area in your submission. What was the second comment that you made? Your voice just dropped off.

Mr Dodd—Health complaints are our main concern. As I indicated earlier, there are other issues that we are concerned about. We are concerned about the limited registration area. But it is mainly health complaints.

CHAIR—The issues relating to the professions are being worked through. But I wanted to get really clear before we talk with the people from those areas later this afternoon that your major focus is on health complaints.

Mr Dodd—That is right. But there are other issues. For example, there is the accreditation issue. We may not have a particular view on that, but it is certainly an issue that lots of people in the community have concerns about and something to say on. What has been suggested in the draft bill is not without controversy, and it is something about which a wide-ranging discussion with the public is needed.

CHAIR—Thank you very much for your time and also your ongoing involvement with our committee. We do value it.

Mr Dodd—Thank you. Of course, PIAC will be putting a submission in in relation to bill B.

CHAIR—I thought you may.

Mr Dodd—We will be talking about some of the things that I have talked about today.

CHAIR—Of course. Thank you.

[9.35 am]

TURNBULL, Ms Helen, Manager, Avant

BIRD, Dr Sara, Medico-legal Manager and Advisory Services Coordinator, MDA National Insurance

EDMONDS-WILSON, Mrs Ellen, Chief Executive Officer, Medical Indemnity Industry Association of Australia

CHAIR—It is nice to have a group of all women giving evidence. It does not happen all that often. I just put that on record so my gender bias is given to the whole world. You are experienced witnesses, so you understand about parliamentary privilege and the protection of witnesses. We have your submission. Thank you very much. If all of you or any of you would like to make an opening comment, please do, and then we will go to questions.

Mrs Edmonds-Wilson—Thank you for providing us with the opportunity to speak further to our submission to your committee. The MIIAA are the peak body for medical indemnity insurers and as a result our submissions limit our discussions to areas on the exposure draft which will have an impact on the 75 per cent of insured doctors represented by our members. Our members cover doctors across all states and territories of Australia.

In our opening remarks today we are focusing on the areas of health practitioner regulation national law, which we believe either will result in outcomes which are not consistent with the desire for patient safety or will have negative outcomes for the community and the health professionals covered by the legislation. My colleagues and I will be happy to answer any questions on our concerns and other issues of interest to the committee, following our short opening remarks.

Firstly, we wish to address mandatory reporting. Whilst the MIIAA are pleased that bill B contains exemptions for professional indemnity insurers in relation to mandatory reporting by health practitioners, we remain opposed to the introduction of mandatory reporting. The MIIAA are committed to patient safety and are opposing mandatory reporting. We are not objecting to the policy objective of protection of the public but, rather, we are objecting to the proposed means of achieving the stated policy objective. Indeed, we are concerned that the introduction of mandatory reporting by health practitioners will have an adverse outcome on patient safety.

A statutory duty to report is likely to create a punitive atmosphere and a culture of fear among practitioners that will limit the open disclosure of issues and potentially drive problems underground. The willingness of health practitioners to openly discuss medical errors is vital to enable the identification of adverse events and the introduction of processes to avoid them. Medical practitioners should be encouraged to seek assistance from their colleagues, the professional colleges, treating doctors and health advisory services. The introduction of mandatory reporting may see a reduction of practitioners' trust and confidence in these services that assist in maintaining professional standards and practitioners' health.

The MIIAA is aware of a suicide of a medical practitioner in December 2008 where the doctor felt unable to seek help or advice from any of his colleagues because of his concern about mandatory reporting. The doctor specifically wrote about these concerns in his suicide letter. We believe that exemptions should be provided for spouses, treating doctors and other professional services such as health advisory services; college performance, support and assistance programs; and peer review processes.

We shall now outline our other major area of concern, which is procedural fairness. The minister saw as key factors in the further development of the new registration scheme an assurance that public protection was paramount, maintenance of a high degree of transparency and an assurance that the scheme should be appropriately accountable. It is accepted that professional regulation is focused on public protection. Due process, however, requires checks and balances. It is vital that appropriate rights of review and appeal mechanisms exist. There should be an appropriate distinction between the investigative body and the decision maker. We believe that the proposed process lacks these checks and balances.

Whatever pathway is taken, whether it is through disciplinary performance or health, the individual health practitioner needs to be protected appropriately. Protection in this context does not imply a protection from appropriate accountability. Rather, it involves protection from unfair process, denial of natural justice, trial by media and scapegoating. The protection of the individual can only occur if there is a clear differentiation between the different pathways within the complaints section that is part 8 of bill B. The MIIAA believes that the legislation should support both the smaller professions as well as the larger ones, but it is crucial in setting up a legislative framework that standards be maintained.

In focusing on mandatory reporting issues which remain unaddressed by the draft legislation and our concerns regarding procedural fairness, we are aware that there are other issues that will be of concern to the profession. We believe, however that these two areas are of paramount importance to the wider scope of professions which will be covered by the legislation and will have the greatest impact on a long term. We believe that the legislation can be strengthened through clearer language and increased delineation of process without, we submit, additional cost. We are happy to answer any questions now.

CHAIR—Thank you. Ms Turnbull and Dr Bird, did want to add anything at this stage?

Dr Bird—No, thank you.

Ms Turnbull—No, thank you.

Senator HUMPHRIES—Thank you for the submission and the opening statement. I agree with your view about the dangers of mandatory reporting. Personally, I think that the arguments apply not just to this area but to a number of other areas where one of the dangers that you very much create with mandatory reporting is that people will not report to services and health professionals and others when they have a problem because of the fear that they will be sucked into a legal system which will be punitive rather than designed to assist them.

Having said that, I also put to you that, in some ways, the horse has bolted on this issue. We now have an accepted pattern of mandatory reporting in a whole range of areas in the

community. If we were to not have mandatory reporting of health professionals who are subject to some kind of disability or misbehaviour or something of that kind that would be setting them aside from others in the community. To give an example of that, if the doctor saw a child that had been abused, under most state laws he would be compelled to report that abuse to the authorities. But what you are proposing is that if another doctor came to the door with a complaint that would otherwise have to be reported he would not have to report that doctor if there was not a mandatory reporting regime there. Can we justify a system which treats doctors differently—some would argue more favourably—to others in the general community because we do not apply mandatory reporting in this area?

Dr Bird—There are already existing ethical codes in the medical profession that require reporting. I guess our objection is to the fact that it would be legislated. It is moving into that punitive area again. Mandatory reporting certainly exists in relation to child abuse for the profession, but there are not many other mandated and legislated requirements. So our argument really is that the existing ethical codes that the profession abide by are sufficient to ensure the protection of the public and also to ensure that the profession is able to function.

Senator HUMPHRIES—You argue in your submission, if there is a mandatory reporting system, for some exemptions. You mentioned the exemption for spouses of health practitioners. How would that work?

Dr Bird—In the case of doctors' spouses, there would be a requirement under the current legislation that if two doctors who were married and one spouse became aware of reportable conduct they would be required in that setting to report it.

Senator HUMPHRIES—I see.

Dr Bird—We would suggest that that should be a very clear exception under the legislation.

Senator HUMPHRIES—But that only applies where two doctors are married to each other?

Dr Bird—Correct.

CHAIR—So not to a doctor and another health professional?

Dr Bird—Actually, you are quite correct—sorry. You are absolutely correct. It would apply if they were one of the other 10 health professionals under the legislation.

CHAIR—There are so many medical practices where the spouse is the nurse practitioner or the office manager.

Dr Bird—Indeed.

CHAIR—It would seem to me that that would be a common process.

Dr Bird—Absolutely, yes. You are correct.

Senator HUMPHRIES—Of course, there would be no obligation on a non-health professional spouse to report their husband or wife anyway, would there?

Dr Bird—Correct—as long as they were not in one of the 10 professions covered by the legislation.

Senator HUMPHRIES—I think that sounds reasonable. You also seek an exemption for health practitioners who perform functions or are employed by medical indemnity organisations. How does that work?

Dr Bird—We believe that bill B, to a large extent, has addressed that issue in that there are exemptions provided in bill B for the operation of medical indemnity insurers or professional indemnity insurers. We will be submitting that the wording could be improved and tightened up in that regard. For example, in the organisations that way we work for the medical indemnity insurers have a number of doctors who are employed. I am one of them within my organisation. That is at a staff level. We have boards and councils on which there are a number of doctors involved. We believe that the involvement of the profession within our organisations greatly enhances our effectiveness in working with, certainly, the medical professionals. So we were quite concerned that if we did not have exemptions for our organisations that would limit the functioning and also that our members might be fearful of contacting us. Certainly when mandatory reporting was introduced in New South Wales in October 2008 a number of the medical indemnity insurers prevented their doctors from taking initial calls from their members as a way of trying to deal with that situation. We would argue that not having that medical input at an early stage reduces the effectiveness of our organisations.

Senator HUMPHRIES—Going back to that issue of a general compulsion to have mandatory reporting, it would seem to me that one way of stepping away from that arrangement would be if there was a comprehensive code of conduct or ethical code that covered that. You mentioned that doctors have an ethical code for dealing with fellow doctors who present with certain complaints or problems or behaviour issues. Are you aware of whether each of the other health professions have similar kinds of codes?

Ms Turnbull—I might answer that. Some of the professions do; some do not. I think it is an excellent idea. It is about the issue of empowerment. We are dealing with a range of health practitioners here. The code of conduct that has been amended by the AMC recently is a very empowering document and is highly supported by the medical profession. It started off as a document which said, 'Do this; do that. You should not do this and you must do that.' Because there was an outcry from a range of organisations, they amended it to say, 'This is the best practice. This is the way to do it.' This is empowering health practitioners to go out and do what is best. Goodness knows it is a tough world out there for any health practitioner at the moment and these sorts of things, such as a code of conduct, are meant to be supportive documents, but if they cross the line then the national boards under this national registration scheme will be able to take action.

Senator HUMPHRIES—To have any chance of replacing a mandatory code regime, you would need to have a code or a set of guidelines which is more than just empowering but is actually compulsory for practitioners to comply with lest they be deregistered and applied across

professions so that if a doctor saw a chiropractor who was misbehaving they would have, say, an obligation to put them into the system as another doctor. It is just a suggestion, but—

Ms Turnbull—I think that it is a matter of language. Our view would be to remove clause 156 from the bill and put it into a type of code or guideline. In New South Wales, for instance, they have an explanatory note or guideline as to what is significant—for example, what a health practitioner should do if they are faced with a drug addicted doctor walking through the door; what steps they can take. Basically, your idea is a very good idea and you can do it in different stages.

Senator HUMPHRIES—At the moment, under the state registration regimes, is there mandatory reporting in any of those situations for health professionals?

Dr Bird—There is in New South Wales. The legislation was introduced in October 2008 for medical practitioners, not for the other health professions. New South Wales already has a code of professional conduct for the profession that Helen is alluding to which did have a statutory basis to it. New South Wales is currently the only state in which mandatory reporting exists for medical practitioners.

Senator HUMPHRIES—Doctors.

Dr Bird—Correct.

Senator HUMPHRIES—So this will be quite a significant change for all the other occupations in every other state.

Dr Bird—Indeed. And even for the medical profession, to be frank. It was only introduced in New South Wales in October last year.

Ms Turnbull—There is an element of fear throughout the profession. People are thinking, 'Should I or shouldn't I? and 'What does it mean for me?' rather than, 'This medical practitioner is working incompetently so we need to refer him to the medical board.' That referral can be for a number of reason, such as for health impairment, underperformance or inappropriate conduct. There are all those steps.

Senator HUMPHRIES—Is the mandatory reporting arrangement in bill B enforced with criminal sanctions or simply the threat of disbarment from practice?

Ms Turnbull—Basically, disciplinary action would be taken.

Senator HUMPHRIES—This committee might suggest that an alternative to this mandatory reporting might be the development of a national code for all health practitioners. That is obviously some way away. I do not think that it is going to deflect the provisions in here on mandatory reporting. But if we recommended that do you think that the health professions concerned would embrace that concept and work towards getting that in place in order to give themselves the flexibility to deal with these situations as an alternative to automatic disbarment?

Ms Turnbull—Absolutely.

Dr Bird—Very much so. You are probably aware that the Australian Medical Council has produced the draft guidelines that Helen was referring to for the medical profession, which I think will be embraced by the medical profession. That gives us for the first time a nationally consistent code of professional conduct for medical practitioners rather than each state and territory board having their own code.

Ms Turnbull—There has been a lot of consultation in relation to it. Its genus was connected with the GMC when they set out their original code of conduct in Britain.

Mrs Edmonds-Wilson—Presumably, it would also be of assistance to the other professions as a foundation for any code of conduct for their own group.

Senator HUMPHRIES—Such a code is only as good as the first story that breaks in the tabloid newspapers about some doctor sleeping with somebody else or whatever and suddenly all bets are off. But it is an idea worth exploring.

Ms Turnbull—That has been the history, hasn't it, particularly in New South Wales? When we have some notorious doctors, we immediately had mandatory reporting as the response. The reality is that there will be other doctors working and doing the same sort of thing, and mandatory reporting is not going to stop them. Basically, the idea is to empower and to encourage a community that tries to increase standards. Mandatory reporting is not the answer to that.

Senator FURNER—Would you be able to provide us with some detail of how many policies you might hold for your members—the number of policies for your membership?

Ms Turnbull—We are from different organisations.

Mrs Edmonds-Wilson—It is actually an issue of competition between the two insurance companies; but to say that there are 60,000 insured doctors in Australia and the companies here represent 75 per cent of that 60,000 will give you an approximate number of the combined policies.

Senator FURNER—Is that 60,000 doctors or is it health professionals?

Mrs Edmonds-Wilson—Doctors only.

Ms Turnbull—We also look after other health practitioners.

Mrs Edmonds-Wilson—Some insurers do.

Ms Turnbull—Some insurers do. And in relation to that the list of the 10 professions within the national realm is pretty well covered, except for chiropractors.

Senator FURNER—In your experience, how many claims would you deal with on average on an annual basis?

Mrs Edmonds-Wilson—We would probably seek advice on that. There is actually a published report from the Australian Institute of Health and Welfare that covers all of the insurance companies. That may provide the detail of the number of claims made against private insurers. We can report back to you on that.

Senator FURNER—That would be good. Have you done any modelling, based on the proposed bill, of any expected rise at all in claims as a result of this?

Dr Bird—I do not anticipate that there will necessarily be an increase in claims arising out of bill B specifically, but we do anticipate that there potentially will be an increase in the number of complaints against medical practitioners, which is the group that we look after, partly related to the mandatory reporting provisions, and also because of the nature of the complaints process that is set out in the bill.

Senator FURNER—Could you go into more detail, based on the second reading position you indicated in your submissions on mandatory reporting, of the limitations on the practising of intoxication of drugs of alcohol and sexual misconduct?

Dr Bird—In what sense? Our view is that nobody would argue that that sort of conduct should be reported. In our experience, from a medical indemnity insurer's point of view, if somebody contacts us and they are suffering from an impairment historically we have always encouraged that practitioner to self report. It is always the best way of managing the situation and we will support them through that process. In that sense, if they were not willing to report, we accept that that is something that should be dealt with properly by the boards.

Senator FURNER—But how did you reach the conclusion that they are the limitations—as a result of this bill.

Dr Bird—What we are arguing are concerns, certainly in bill B, about the definition of 'reportable conduct', when it comes down to the issue of an individual practitioner's conduct. In our view, the bar has been set quite low. It talks about conduct and there being a risk of substantial harm and a departure from accepted professional standards. That is really just a test of negligence. Most procedures or anything that you do in medicine can unfortunately have a risk of substantial harm to the patients you are dealing with. So our argument is that, if you are going to have that as part of your definition and part of management reporting and if you do not want the boards flooded with complaints potentially leaving them in the situation where they cannot see the wood for the trees, you need to set that bar. What you are really looking for is conduct that is a significant departure from accepted professional standards or a flagrant departure from those. In our view the emphasis is on the wrong arm. If you are just looking at harm to patients, you are not capturing. You should be looking at the conduct and the competence of the individual health practitioner.

Senator BOYCE—We had some evidence yesterday from the Pharmaceutical Society about a peer support program that they had set up in Victoria. Are you aware of this program at all?

Mrs Edmonds-Wilson—Not of the pharmaceutical one, no. But the Royal Australasian College of Surgeons have a peer support program which we in fact were involved in establishing with them. It is a quite detailed performance pathway to assist doctors who are having

difficulties. We have grave concerns that that sort of program would be affected by the legislation.

Senator CAROL BROWN—Can you perhaps describe for us the Australasian College of Surgeons program and how it works?

Mrs Edmonds-Wilson—In general terms, if a doctor is identified by his or her peers as having performance issues, the college then works with the problem doctor and gets someone in to work with them to develop their skills to the standard. It is a self-assessment tool, too. The doctors are actually given a checklist—for example, this is what is acceptable practice and where do you think you sit within that? They identify where their weaknesses are and then the college assists them to get them to the college standard once more.

Senator CAROL BROWN—So there is the potential for surgeons to self-identify as well?

Mrs Edmonds-Wilson—Absolutely. It is a self-assessment tool in the first instance. But you could be encouraged by your peers to fill in the self-assessment form.

Senator CAROL BROWN—The Victorian pharmacy one, as I understand it, is a telephone support program which is anonymous. Given that you are aware of the surgeons one—

Mrs Edmonds-Wilson—There is also the Doctors' Health Advisory Service. When a doctor is having problems, they can ring up this central number and speak to another doctor and get support from.

Senator CAROL BROWN—So that is primarily for GPs, is it?

Mrs Edmonds-Wilson—No, it is for all medical professionals.

Dr Bird—It exists in every state and territory in Australia. From what you were saying, it sounds quite similar to the scheme that you were talking about. That is quite well developed in every state and territory. In our submissions we talked about the health advisory services. They are called the Doctors' Health Advisory Service.

Senator CAROL BROWN—You said that you have some concerns about what mandatory reporting does to that. Can you list what you see as the problems?

Mrs Edmonds-Wilson—Our concern is that doctors will not seek advice when they need it, that they will continue to operate without any supporting mechanism, and patients' safety could potentially be compromised by that. Whereas, if they had sought assistance from the Doctors' Health Advisory Service or a similar service, they would have obtained assistance and addressed those issues and either had advice that said, 'You should report yourself', as insurers recommend, or had actually sought treatment for their problem.

Senator CAROL BROWN—What sort of position do you see these advisory services being in legally—

Mrs Edmonds-Wilson—They have no protection.

Senator CAROL BROWN—If mandatory reporting comes in, they would more or less be obliged to report.

Mrs Edmonds-Wilson—They would have to. My personal view is that they would cease operating as they would be so compromised in their ability to provide private, confidential support. They would not want to expose themselves to that risk.

Senator CAROL BROWN—And you have taken on notice that idea of giving us a sense of how many report come in.

Mrs Edmonds-Wilson—We would not know how many go to the Doctors' Health Advisory Service, because it is on a confidential basis. But we can certainly seek information on—

Senator CAROL BROWN—It would be useful to have a sense of how many phone calls or contacts are made with all the services that you are aware of that do assist with peer support. That would be a good thing. The other area I wanted to talk about briefly was what some witnesses have thought might be accidental or deliberate inclusions and exclusions that have popped up in bill B—for instance, the fact that cervical manipulation is the only type of spinal manipulation that is specifically covered now. From what we are being told, anyone can do spinal manipulation but not cervical manipulation under the proposals that are in bill B. Do you cover in any way people who are non-medical but practise in this area? I am thinking of naturopaths, masseurs et cetera.

Ms Turnbull—We do not cover them at all.

Senator CAROL BROWN—Is this an area that you have looked at at all? What was being put to us was that there was this sort of black hole of people who it would not be possible to pursue if they damaged you in any way because there was just nowhere to take them.

Ms Turnbull—I think that is right. I think that there is a black hole. From attending the national forum and the state forums in respect of bill B, I think there was a real concern about who could do spinal manipulation and who could not and how dangerous a procedure it was. But this is out of our area.

Senator CAROL BROWN—So you have not looked at the scale of that market?

Ms Turnbull—No.

Mrs Edmonds-Wilson—The members of the association are restricted to the insurance of doctors, generally speaking. They were established as medical defence organisations.

Senator CAROL BROWN—I just wondered if you had looked at other parts of this very large market. Would podiatric surgeons currently be covered by your insurance?

Dr Bird—Not by MDA National.

Ms Turnbull—I am not sure.

Mrs Edmonds-Wilson—Unless they were registered medical practitioners, it would be unlikely that they would be covered.

CHAIR—The only question I have is around the questioning you were having with Senator Humphries—it is around the whole issue of mandatory reporting, which is the main thing in your submission. In reading the background and the ministerial statement about why they brought it in, the statement is 'to give surety and confidence to the public'. That is the rationale. Comments have been made that there is a view in the public that they feel as though doctors protect doctors. It is quite an entrenched view—when you go to community forums and things of that nature.

We certainly have not questioned on this issue, because the mandatory reporting came in between the original draft and bill B. So we have not spoken to the group at all. We will be talking to the National Registration and Accreditation Implementation Project at two o'clock this afternoon. There must have been some lobbying around this area. I know you have mentioned in your submission and also in your evidence that people will be more confident and will work together to lift standards in terms of having their non-mandatory report. But when there is a perception out there about this 'club' arrangement and it has been proven in some significantly serious issues that have come before the public in trials that doctors have been aware of their comrades and have had genuine fears that their comrades have been doing the wrong thing but nothing has been done, what is the response when you are talking with the community about those issues? How do you convince them that we are not just once again allowing self-regulation? Self-regulation has a very bad name. They do not even allow politicians to self-regulate. What is the response to those concerns and fears?

Dr Bird—I think the medical profession is highly regulated. We are all responsible to our medical boards, and we touched upon earlier the codes of conduct which have been widely promulgated amongst the profession. I have been fulfilling this role within a medical indemnity insurer perspective for 10 years now. What you are really aiming to achieve in the profession is a culture change—so that we have a just culture and an understanding of our broad responsibilities. I think there has been a change and we have seen those issues brought out into the open. One of the markers of doctors who do get into trouble is that they are the ones who are isolated. They often do not recognise that they are an outlier, because they have nothing else to benchmark themselves against. Our argument is that the importance of being able to discuss things with your peers, if necessary, with your treating doctor, with your college group and so forth is part of producing that culture to ensure that the profession and those individuals within it are all meeting that same standard.

I guess my argument would be that I see mandatory reporting as a retrograde step. It is going back to that naming, blaming and shaming of individual practitioners. The literature and research show that a lot of the errors and adverse events that occur in medicine are the result of systemic issues and, unless we are able to bring them out into the open, we are unable to address those issues within our health system. If you just individually take out a doctor who you label as a bad doctor, often you just remove somebody who could be practising at a high level. That is the concern: that you are introducing this very punitive atmosphere for the profession, which has, I think, over the last 10 years tried to develop a just culture and bring those issues into the open.

CHAIR—On the other side, my concern is the idea of frivolous and malicious complaints in terms of professional jealousies and those kinds of things. If anything, that gives me more fear,

particularly now that we are talking across professions where there has been, quite clearly, some historical competition between professions. If we have time, I will certainly be putting on notice with Dr Morauta what research has been done on that. I know Senator Williams had views in that area between professions. There are arguments on all sides. It is a really important question, and we do appreciate the effort that your association has put in in bringing forward your concerns. Have you raised these concerns with or put them to the project?

Mrs Edmonds-Wilson—Yes, we have. We have been quite consistent in our submissions.

CHAIR—Very good. Thank you very much for your time. If there is something that we have not raised or you think that we should have and you think of it later, please get in contact with the secretariat.

Proceedings suspended from 10.11 pm to 10.46 am

FRANK, Mr Ian, Chief Executive Officer, Australian Medical Council

MENZIES-McVEY, Ms Drew, Research and Policy Analyst, Australian Medical Council

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submissions. I now invite either or both of you to make some opening statements, and then we will go to questions. Mr Frank, this submission was written before bill B, so there may be some changes.

Mr Frank—That is correct. Absolutely.

CHAIR—That is happening all the time, but I just wanted to check that. If you would like to make an opening statement.

Mr Frank—Thank you very much, Senator Moore. I think on behalf of the Australian Medical Council it is worth noting—and I am sure the senators already have—that the proposal to establish a national registration and accreditation scheme is probably the most significant and radical change in the regulation of health professionals since the legislation to regulate the medical profession was introduced in the mid-19th century. No previous regulatory reform initiatives that we have seen in Australia have had to deal with the scope and the complexity of the matters covered in the proposed NRAS arrangements. Not only will there be a complete change in the legislative basis in which the health practitioner regulation operates but also there will be a complete change in the infrastructure and administrative systems that will support the new regulatory models. A number of these processes—notably, in the complaints, performance, health and conduct areas—will represent significant departures from established practices in some jurisdictions.

The Australian Medical Council, as a national standards body, has been involved for some 20-odd years in the accreditation of medical schools and, more recently, the specialist medical training programs in Australia and New Zealand. We have been involved in the examination of overseas trained doctors leading to registration in Australia, and we have been working with state and territory medical boards on uniform approaches to registration.

The AMC would like to commend the members of the national registration and accreditation implementation team for their efforts in drawing together the complexities of health practitioner regulation in Australia into a single piece of legislation. The AMC notes that many of the issues raised in previous submissions on the NRAS developments—and these were in response to the consultation papers that were put out in 2008—have been reflected in the exposure draft of bill B. We also note that there are still some outstanding matters of principle and matters of clarification and definition that require some further attention. These are being addressed in the national forum and in the state forums that are being held by the implementation team. However, from the accreditation assessment perspective the AMC considers that the mechanisms and processes outlined in bill B are workable subject to clarification of a number of those outstanding matters. The issues that are of specific concern to us relate to things like the definition of the accreditation standard in the draft bill, which we feel is slightly too narrow. It should reflect learning and a continuous quality improvement of medical education.

We believe that the intervention of the ministerial council, in section 10, on matters relating to workforce supply and recruitment again may be slightly too narrow. There needs to be a balance between quality and safety and supply issues if we are really to address public interest. In particular, we believe that the complaints processes, particularly the combining of performance with conduct and impairment issues, is in fact a retrograde step. It is not in keeping with international developments in this area and does not reflect best practice. It needs to be understood that performance assessment is a proactive process. It is a risk management process, not a reactive or responsive process. It is very important that that matter be addressed if this is to work effectively.

We believe that in the current wording of bill B there is a lack of flexibility in the complaints-handling process; in particular, the fact that it appears as though a case has to proceed to the end of one pathway before it can be shifted across to another pathway. If, for example, a case is identified, perhaps from a complaint, which really relates to a performance or impairment issue, it does not appear to be very simple to move it across into that other area. You have to progress all the way through to the end of the conduct or complaints process before you can move it across into the other areas. Again, we think that would slow the process down and add to the time it takes to process these cases.

We have some concerns that the composition of the national board, as set out in section 45, which allows all of the larger states but only one of the three smaller states to be involved in the national board, is probably a retrograde step. Certainly our experience with input from the smaller states and territories in Australia in relation to things like area of need registration and the very heavy reliance on overseas-trained practitioners is that they have a unique set of circumstances and problems, particularly in relation to supervision, monitoring, setting of conditions et cetera. We feel that for them not to be included in the format of the national board is probably a retrograde step and has an unfortunate historical dimension, too, which I will come back to later.

With regard to the category of limited registration, we support the notion that it should be specifically limited but we feel that the targeted period of two years is too short and that that is going to have a significantly negative impact, particularly in research and postgraduate training and in teaching and research positions as well. We suggest that that should be taken out to four years, with annual renewal.

We have some concerns about the current wording of bill B in relation to title and practice protection. We note that the communique issued by the health ministers on 8 May indicated that people who are registered under area of need categories would not appear on the specialist register. At the moment there is some confusion about people appointed to area of need who can hold themselves to be specialists when in fact they have not met the requirements for assessment as an overseas-trained specialist in Australia. We feel that there needs to be some capacity in bill B to distinguish between a title—in other words, a designated field of medical practice—and the term ‘specialist’. We understand that was the intention, certainly, in the communique but we feel that it was not necessarily reflected in bill B.

Having said these things, we do know that there has been discussion going on, as I said, in the national and state forums. We have also had discussions with members of the national registration and accreditation agency implementation team about these issues and we understand

that there will be some modifications made to the draft of bill B to accommodate some of the concerns that have been raised. The one concern we have about it is that we understand also that once we and all health professionals and other stakeholders have made their submissions we will not actually get to see another version of this bill. It will go straight to the Queensland parliament and enter into that process for debate. The concern we have is that the complaints process in particular is a really critical part of this exercise. If it were at all possible to at least have that section of the bill viewed by the people who actually operate the complaints processes, it would be very valuable in ensuring that when the thing is finally implemented it actually does work in the field. We have some concerns that, as currently written, that may not be the case.

CHAIR—Thank you. Ms Menzies-McVey, do you have anything to add?

Ms Menzies-McVey—Not at this time, no, thank you.

Senator HUMPHRIES—Thank you for that evidence. In your original submission you raised concerns about the accreditation arrangements in the then version of the legislation not complying with the World Federation for Medical Education and WHO guidelines.

Mr Frank—Yes.

Senator HUMPHRIES—I assume those fears have been eased by what is in bill B?

Mr Frank—The communique made it very clear that the accreditation process would be free of interference by governments, and our reading of bill B suggests that that will be the case. The ministerial council, for example, while it can give directions in matters relating to an accreditation standard, cannot give direction in relation to the accreditation of a specific program or the assessment of an individual or conduct matter. That means that at least the accreditation processes, the review of individual training programs, will be free of any sort of government interference, as it were.

Senator HUMPHRIES—The one exception to being able to give a direction I think is in relation to standards relating to workforce shortages.

Mr Frank—That is correct.

Senator HUMPHRIES—Are you comfortable with that exemption?

Mr Frank—If you look at the stated objective of the legislation, you will see that it is to provide protection to the public by ensuring that only qualified medical practitioners can be registered. We feel that there is a very fine balance between workforce supply and quality and safety issues. Unfortunately, if you look back in time then you will see that whenever workforce has become an issue quality and safety tends to sort of fall off the agenda a bit. There is a tension between those two. We do not have to look back very far in time to realise that recently in our near north this became a serious issue when existing established assessment processes were bypassed in the interests of supplying a workforce to a particular health service. While recognising that workforce supply is a very important issue in the delivery of health services, we believe that public interest would best be met if that was balanced with quality and safety issues

as well—not simply looking at recruitment problems or workforce supply problems alone. That is the submission we will be making to bill B.

Senator HUMPHRIES—I know that bill B gives the ministerial council the power to nominate bodies that will be accrediting bodies. Some witnesses from professional organisations have suggested to us that there is the power there for the ministerial council to effectively play politics by deciding to bypass the existing accreditation bodies in favour of others. You have already been a designated as the accrediting body with respect to doctors. Realistically is there another organisation that could be nominated as the accrediting body for doctors other than the AMC?

Mr Frank—I think there are any number of combinations of bodies that could be put together to undertake that sort of process. But I note that, first of all, we have been assigned the accreditation function for the first three years of the scheme. I also note that section 290 talks about a review. The national boards must take undertake a review of those arrangements and make recommendations to the ministerial council. I think a lot of people who have been expressing concern about this particular aspect of the bill would feel more comfortable if, for example, the ministerial council were to make decisions based on advice from the national board, because the national board has some expertise in the area and would be an appropriate body. But if we read section 290 under the transitional provisions, we see that in effect that is what is going to happen—because within that three-year period the national board will undertake a review; and the national board will make recommendations to the ministerial council about assigning the functions beyond that three-year period. So we are comfortable with the way that mechanism, taken as a whole, will operate at this point.

Senator HUMPHRIES—So, to summarise, you are saying that it would be possible to play a bit of politics with this but really the dynamics of the relationship between the board and the council, and the way that the professions work and so on, makes it unlikely that those sort of games could succeed.

Mr Frank—A lot has been said in the media about this business of the independence of the AMC's accreditation process. The reality is that the AMC's accreditation process has never been guaranteed. We have been subject to ministerial direction throughout the entire 20-plus years that we have been operating here. All of the processes that we have put in place and that are recognised as high-quality processes have been undertaken during that period and under those arrangements. In fact in a way, having assigned the function to us formally, we are actually better off now than we have been in the past. So we are less concerned about this.

At any point in time governments, both singular and plural, can make policy decisions and change direction and follow all sorts of different lines of development. But basically we have a robust, well-developed system. It is compliant with World Federation for Medical Education guidelines. It has very great stakeholder involvement and participation and a lot of support from the individual people who participate in the programs. It would be a not impossible task but a very difficult task, I think, to recreate all of that and still maintain a high standard accreditation system. So I think that we will have to, along with all the other health professions, make our case and demonstrate the effectiveness of our processes and the integrity of our processes, but that is something we have been faced with since we were first established in this area.

Senator HUMPHRIES—Let's play devil's advocate here and suppose that in three years time the arrangements are being reviewed and a commercial operation gets together a number of doctors to establish a doctor's accreditation company to offer a service to accredit doctors and courses and things like that cheaper than the AMC can do it. Is that the sort of proposition that might ultimately tempt ministerial councils to bypass the AMC?

Mr Frank—It might, but what is the purpose of the accreditation? One of the things that the accreditation process is designed to do is to give both the community and the profession confidence in the outcome of the training programs. Sure, anybody can put together a group—and I can think of a couple of companies that could probably mount something like this—but would they have the buy in from the profession and the acceptance of the outcomes of the process? It is hard to say. It has taken us 20 years to get it.

Senator HUMPHRIES—And you are confident that the governments concerned would see that as the highest priority?

Mr Frank—It is not going to work if you do not have the buy in of the stakeholders. We are not talking about just one or two people; we have something like 500 people who support our accreditation assessment processes. These are people at the top of their professional standing. I believe that if you poll the groups that we are looking at—be they medical schools or specialist colleges—you would find that there is great acceptance of the integrity of the accreditation process. Without the cooperation of all the parties concerned, even if it is a tad cheaper I do not think you are actually going to get that to work. Internationally that has proven to be the case in North America and Europe as well.

Senator HUMPHRIES—Turning to a different area, you raised the issue of the representation of the small states. A witness yesterday made the comment that they thought the national boards should really consist of the best people in the areas—that people should be chosen basically on the quality of the input they can have into the process and that an overly strong focus on representation for every state could detract from that process. That seems to be a little different to the tangent that you have taken. Do you think they are right?

Mr Frank—I agree that you obviously always want to have the best possible people involved in your processes but I think there is another dimension here. If you look at what the bill is going to entail, you see that it will involve making decisions on a lot of very local issues, imposing conditions that have to be monitored and implemented locally, and looking at specific circumstances and challenges that come up locally. We can unpack that just for a second and look at places like the Northern Territory. I think the average around Australia of overseas trained doctors as a percentage of the workforce ranges from 25 per cent generally to 35 per cent in rural areas. In places like Alice Springs it is over 55 per cent. There is a huge dependence on overseas trained doctors working in that environment, and they bring with them their own set of unique situations and problems. Having people who fully understand the environment in which they are operating and who can advise in developing national policy on how you might handle some of these issues I think is really very important.

Similarly, in Tasmania there are a unique set of circumstances there. Some of our major issues around problems we have had with area of need registration over the years have emerged from there—and the ways of dealing with those are unique to Tasmania. They do not have the same

resource base that we have on the mainland or that we have up and down the eastern seaboard. So the way in which they are actually solve or deal with those problems and protect their community will be very different to the way it might be done in the larger states.

By all means, I think you can put together a team of people who are experts in their field but I think that the knowledge of the local environment at that level—particularly in the initial period when we are sitting setting up the system—is going to be very important. I know that they are proposing to have local boards or local committees in some cases, and they will be very important obviously. But I think it is really important at the highest level in this area, where you will be setting the policies and setting the processes that will be monitoring standards and ensuring that people's performance is being monitored closely, that you actually have input from people who have first-hand knowledge of what happens in those environments. The AMC have had that involvement in all of our processes over the years. We have had some difficult times with it occasionally, but it has been very valuable to have that degree of detailed input into the process.

The other thing, just as an aside, that is really quite interesting is that historically the first time that legislation was used to reinforce professional standards in an English-speaking country was in the mid-1800s. Everyone assumes that came from the UK. It did not. Although the GMC was established in the 1850s, it was actually Van Diemen's Land that passed the first piece of legislation to regulate the practice of medicine anywhere in the English-speaking world in 1837. It predated the GMC by a considerable period of time—a fact that we love to remind our colleagues in the GMC of at every possible opportunity! They were forward thinking in those times. The reason for doing it at that stage was that there was a need to distinguish between people who held themselves up to be practitioners and people who were legally qualified as medical practitioners. That is where the legislation came from. I just think it would be a great historical sadness if we actually dropped Tasmania from that system now given that they were the guys that got it started in the first place.

CHAIR—Senator Brown probably has a view on that!

Senator HUMPHRIES—Yes, the senator from Van Diemen's Land is looking very pleased with herself over there. What you have said about looking at local conditions in a particular place like the Northern Territory reflects back on this argument about the need arguably to make compromises in the cases of areas of need. Other professional groups have said to us that it is absolutely vital that we not compromise standards in order to cater for problems in areas of need, although most could see that some compromise is necessary on the fringes. Do you take the same view, that some professional standards may need to be relaxed in order to deal with the problems of not being up to get doctors in particular geographical areas or areas of practice where there simply are not available practitioners?

Mr Frank—I think that from a standards point of view we would be very reluctant to support that approach. There are ways in which you can deal with the problem. For example, up until about 2002 area-of-need registration in terms of specialist practice was not really subject to any formal review. If a position had been declared an area of need and if somebody was put forward by a local health authority they were registered and that was it. Around that time a process was developed that tried to match the criteria and needs of a particular position to the actual qualifications and experience of an individual practitioner. This might be a practitioner who

might not meet the standards for registration as a specialist in Australia but has the necessary skills set to undertake work in that particular area-of-need position. A fairly classic example is that you can actually designate positions in, for example, ear, nose and throat, ENT, for someone who is only putting grommets in children's ears. They would not be doing any advanced cancer surgery in the throat area or anything like that. They would not qualify as a fully trained specialist in the ENT field but they would have the necessary skills to work in that specific area.

This has been going since 2002 and a number of people have come through that process. It has been a mixed bag. Some of it has worked and some bits have been a bit of a problem—usually because the assessment processes have been bypassed. Where the processes have not been bypassed, it has been possible to get somebody into those positions that can undertake the work at the level that is required—not beyond that level but at the level that is required. That is where having appropriate supervision models and knowing what the circumstances in the local region are and the extent to which supervision can or cannot be put in there becomes a critical issue.

I think there are processes that can deal with the area-of-need situation. We have a bit of a track record. Some of it has been good and some of it, as in the case of Bundaberg, has not been so good—but then that taught us a lot as well. But the critical part is knowing what the circumstances are like to then be able to ensure that the appropriate supervision mechanisms, reporting mechanisms and monitoring processes are able to be put in place. The fact that you can do that in outer metropolitan Sydney or Melbourne does not necessarily mean you are going to be doing it in outback Northern Territory, Queensland or anywhere else. Again, knowing what those circumstances are is very important to the process.

Senator CAROL BROWN—I want to go back to the composition of the national boards just for a moment. You touched on the issue that local boards will be established, but the draft bill indicates only that they may be established. There has been a school of thought that those local boards may only be established for the larger professions. Do you have a view on that scenario?

Mr Frank—Yes. I think that creating a massive infrastructure when you really do not need to do it because of the demand, the flow of business and pressure of work is probably not a wise idea. So we accept the fact that in some of the smaller professions in particular it may be possible to handle those things through, say, an ad hoc committee that is assembled to look at a particular issue rather than having a standing committee or standing board, as they are beginning to call them.

However I think it is very important that we put this into a context in terms of medicine. In those states, like Queensland, where we have had multiprofessional offices—where one office has looked after 13 health professionals, as happened recently in Queensland—the data we have got back from that tells us that, of all the complaints that come in on all of the conduct issues and all of the performance issues, 80 per cent of them relate to medical practitioners and 20 per cent relate to all of the others put together. So that suggests that it is likely that you will have a demand for people on the ground to deal with these matters. That would suggest—certainly in terms of medicine; I cannot speak for the other professions because we do not have enough information about them—that the demand would be there and that you would need to have some standing group at the local level to handle the volume of material that is going to be coming through. It is unfortunate but that is the way it is.

Senator CAROL BROWN—In your view, if there was a state board of the medical board of Australia—as I think it would be called—do you think that would be sufficient for those jurisdictions that have will not automatically have a seat at the table?

Mr Frank—We do not yet know enough about the detail of how those state boards are going to be configured. We assume that they will be closely representative of the kind of processes that go on at the state levels now. They vary slightly from state to state, again depending on size, volume and so forth. Assuming that that same sort of model goes over then at that level—at the initial processing level—you will have the resources to be able to do what you want and you will hopefully have people who will be familiar with the local area to do that.

If you actually look at the bill though, you will see that there are some serious issues that are developed at the national level and it is at that level where I think the input is needed. Whether it is co-opted or whether it is their from day 1 as a member of the national board—there are a number of ways that could be achieved—I think it is absolutely essential that at that level you do have people with first-hand knowledge of the local environment. They should be the best available people in terms of their skills sets and their knowledge. I think that is where some of that decision making is going to become very important.

For example, we know that our council as a full body only meets twice a year and most of our work is done through standing accreditation committees or boards of examiners. But having the input from those council members on issues around how we structure examinations, for example, or how we look at specific accreditation issues that have come up—I am talking about having those voices at that council—has enabled us to guide the process much more efficiently than if we had to go out into the field and try and establish some of these things on the run. I think it is very important that you have that membership there.

Senator CAROL BROWN—Do all jurisdictions in Australia have teaching medical schools?

Mr Frank—No, the Northern Territory has teaching undertaken there but we have not yet established an independent school. It may come. There are some proposals which we understand are in the wings. They do not yet have a school but they do have students sent there from other states to undertake training. Those processes are then usually accredited as part of the particular institution. So Flinders University from South Australia, for example, may send students up there and we accredit that as part of the Flinders program in South Australia—even though the teaching is actually undertaken in the Northern Territory.

Senator CAROL BROWN—So the Northern Territory is the only jurisdiction without?

Mr Frank—Yes, it is the only one at the moment that does not have an independent medical school, if you want to put it in those terms.

Senator CAROL BROWN—On that point about the national boards, I am thinking about the issue of critical mass—and I am talking particularly about Tasmania—of the 10 health professions that are covered under the exposure draft. I know you probably cannot answer for other professions, but I am concerned that there might not be that mass of professionals in Tasmania that would be able to be on every national board.

Mr Frank—I agree entirely and that is why I said that there are some areas where the numbers will not justify it. I think I am right here in saying that there is one registered podiatrist in the Northern Territory.

CHAIR—There are two. They are growing.

Mr Frank—They would be exceptionally busy if they are going to be running the board. So clearly that is not a viable model. But there are other areas which—either because of the size of the profession, in the case, for example, of nursing; or the volume of business, in the case of medicine; or where it sits in the clinical decision-making process—might warrant having a particular approach. So you may have in Tasmania a standing committee dealing with medicine, perhaps one dealing with nursing and maybe some combined ones dealing with some of the others—I do not know; there may be different ways that that can be done—because of the volume that is there, whereas in other jurisdictions you will have standing committees for perhaps nearly all of them. I think that may vary locally, but certainly at our end, and with some of the other larger groups, and with groups that have a fairly significant impact on patient safety and wellbeing, that is where these issues become much more important.

Senator CAROL BROWN—Local knowledge is, I believe, always viewed as a very valuable commodity when you are putting together policies. In your opening remarks you mentioned the consultation process and that, after the final draft of the act, you would like to see a further consultation.

Mr Frank—The AMC is not directly involved in registration and conduct matters, but we have been working with the medical boards over the years in this area. We feel that, even if, for whatever reason, you cannot release the final version of the entire bill, at least having those people in a couple of the health professions who are heavily involved in conduct matters look through and map the processes in terms of how they would work in the field, given the known cases we have had, would be very useful. We had a very productive meeting last week with the drafters of the bill where we brought all the medical registrars together to talk about individual cases they have had that demonstrate what happens if you try to plot a case through this system—how complex it is and where the delays are likely to occur. I think that was a very valuable exercise. Depending on the wording of the final bill that goes forward, I think it is critical that we have that kind of input for that particular part of the bill. Most of the rest of it is fine-tuning things that I think we can live with, but that is one part that is going to have a huge impact on the community if we do not get it right. So, if that piece of the legislation could be shown to those people who have got first-hand experience of complaints-handling processes and the registration processes associated with that, it would be a very valuable way of moving this thing forward and progressing the bill.

Senator CAROL BROWN—Could you explain, on a broader consultation level, what involvement you have had with the consultation process up to now.

Mr Frank—There was the national forum on 19 June, which we were invited to attend. A number of the people who are on the Australian Medical Council through the state medical boards have attended the state forums that have been held on that. A couple of the people associated with the Australian Medical Council are on some advisory groups that have been set up by the implementation team to advise them on aspects of the legislation, particularly in

relation to registration matters, and we were invited to talk to the drafters of the legislation last week specifically about the complaints-handling processes and the associated issues around complaints performance and conduct matters.

Senator CAROL BROWN—Have you put in written submissions as well?

Mr Frank—We are finalising it and it will be going in on Friday.

Senator CAROL BROWN—Will that be your first written submission into this process?

Mr Frank—It will be the first submission to bill B.

Senator CAROL BROWN—Okay.

Senator BOYCE—Mr Frank, you mentioned in your original submission to us the concerns about the innovation and continuous quality improvement of training and education being perhaps stultified by the system that was being established. I take it from what you were saying that it was primarily the structure and the reporting processes that you thought might cause this. Is that the case?

Mr Frank—One of the issues is that we feel that the definition of the 'accreditation standard', which talks about knowledge, skills and attributes—that sounds perfectly reasonable; most of our standards are written around those sorts of concepts—has the real danger that, if you have a process that focuses on workforce alone, what you tend to look for is having a workforce that can function when it exits its training program. So, as the workforce comes out of the university programs or the other college programs, it can actually function at that point. The concern we have got is that medical education is actually a lifelong process. What you really need to do is ensure that the accreditation standards are robust enough to ensure that there is a continuous educational process inculcated in the graduates. If you just stop and think for a second, most of the people who today are specialists working in the field of radiology are using equipment that did not exist, even in concept form, when they finished their medical training. They are using stuff that did not exist. If you think of people who are working in the field of genetics, most of the science did not exist in pre-1983. So, a lot of the people who are now out there using this material were trained in a way that gave them the basis on which they could assimilate new information, new technologies, new techniques, new knowledge about medical sciences and new knowledge about the disease processes as these things came along.

Senator BOYCE—But that is not going to change that much, is it?

Mr Frank—In relation to standards, one of the clauses in bill B, for example, talks about knowledge, skills and attributes and a second clause later on talks about knowledge and skills. If you are just ticking off people's skills sets at the end of a training program you are not actually creating a workforce for the future. The objective of the bill talks about having a sustainable workforce with capabilities of innovation into the future. If that is their intention, and that is what is stated in the bill, the definition of things like the accreditation standards should reflect that, and we will be making a submission along those lines.

Senator BOYCE—How would you propose that that—

Mr Frank—I think that the standard needs to refer to continuous practice—not that a person is capable of practicing at the time of graduation but that they can continue to develop and evolve their processes—and that the systems that you build and the institutions that you look at have actually got elements built into them that can sustain that process; they would have elements of exposure to, say, innovation, research et cetera so that the trainees do come out with a focus on lifelong learning and not just simply a skills set that enables them to function on day 2 or day 3 of their entry into the workforce.

Senator BOYCE—Would that primarily be just around changing the definition?

Mr Frank—I think so. There are some other interesting elements. There is a lovely section in the bill that talks about transparency; it provides for the accreditation entity to publish the findings of any accreditation outcome where the accreditation has been refused by the national board, but it does not talk about publishing it when it has been accepted by the national board. That has clearly got to be an oversight, but it is one that we would want to clarify.

Senator BOYCE—So you would see that as being a way of spreading best practice?

Mr Frank—There is no doubt. There is a lot of evidence both nationally in Australia and internationally to show that well-developed accreditation is a very strong driver of change. The most recent stuff done here probably would have been the ACCC's review of the Royal Australasian College of Surgeons in around 2000 or 2001.

Senator BOYCE—Could you repeat that.

Mr Frank—The Australian Competition and Consumer Commission did a major review of the College of Surgeons because there was a complaint that they were stifling competition. As a result of that exercise, and the work that we were doing at the same time on accreditation, they exempted all the other colleges from submitting applications for full reviews because they were complying with the accreditation process. They were able to see that the colleges that had already participated in accreditation were able to supply all the information the ACCC needed to demonstrate how their processes were operating. So we know that the accreditation operates. Internationally, it is the same thing. There is a lot of evidence to indicate that accreditation is a very powerful driver of quality improvement if it is properly implemented. The three things that we needed to know were: firstly, that the standards that are developed reflect international best practice, not just simply some particular local requirements, although local requirements are obviously important in that; secondly, that the accreditation authority has the capacity to appoint the right team to undertake the accreditation. We have found that that is actually one of the critical parts of the process. If you put the right group in that matches the particular challenges that an institution or a training program present to you, you get a very powerful accreditation outcome. The final thing was that the accreditation recommendations be public. So, once we have made the recommendations to the national board and the board has made its decision, that becomes part of the public record and everyone can see what has actually happened in that process. It is by spreading that information across all the training program providers or all the colleges that you can actually drive a lot of curriculum improvement, assessment improvement, improvement in clinical placements et cetera. They have become very important. So, making the processes open and transparent is very important to the outcome.

Senator BOYCE—I am sure that, as you said, the assumption was made that good accreditation practices will be happily reported; it is perhaps just the ones that fail that will not be.

Mr Frank—Yes.

Senator BOYCE—Some of what you are talking about is in fact somewhat counterintuitive. Where you do not have competition you still have innovation and development. You talked earlier about the Medical Council and the situation that might arise if someone else were to be replacing or competing for the Medical Council's view. Has the Medical Council looked in any way at the expansion of its own education and training into other health professions?

Mr Frank—We have worked with the Australian Dental Council, because there is a program, called oral and maxillofacial surgery, which combines both dental qualifications and medical qualifications. It has been approved for Medicare purposes, and we were asked to undertake an accreditation program. It was appropriate to do it as a joint program, because some of the people will be registered as medical practitioners and some will be registered as dental practitioners. It highlighted for us some very interesting issues. One is that it is very easy to overengineer a process for another profession. The specific needs for dentistry, for example, may in some areas be slightly different from the needs in medicine; therefore, we would have to work very closely with the other groups to try to tailor the process.

Senator BOYCE—So what you are saying is that you do not want to end up with a sum of the two?

Mr Frank—Yes. You need to really tailor it to suit the particular challenges and requirements of the area you are looking at. Since the national registration scheme was announced in 2006, all of the 10 health professions that are captured by the scheme have formed a working group of their accreditation bodies. That working group has already arranged to exchange training materials and various information on processes that we have. Clearly, there is a lot of scope for development in that area. I think that the council at the moment has its hands full dealing with the vagaries and challenges of medical education. We would not want to leap into taking over for somebody else, but we are quite happy to share expertise, information and resources, particularly in things like the engagement and involvement of health consumers, which we now have in all of our processes but a lot of others do not. We have built up some training materials and programs that can help those other bodies if they wish to take consumers into their accreditation processes. That has been very successful from the AMC's point of view.

Senator BOYCE—That leads me to my last questions, which are about consumers. I believe you commented that the complaints system that exists is designed to be proactive, not reactive.

Mr Frank—No, there are two parts of it. The complaints processes as they stand in all the states and territories at the moment and as they are represented in draft bill B are essentially reactive processes. In other words, a complaint is made and then the complaint is responded to and there are various pathways and processes that occur. The exception to that is performance assessment. Performance assessment arose out of work that was done in North America about 10 years ago in which they came up with the notion that if you could identify suboptimal performance before it became a problem and then put people through remediation programs or,

if there is an impairment issue, into the appropriate impairment program then you could head off the potential problem down the track. It is really a risk minimisation and mitigation type of process, and it operates differently from the normal complaints process. That is how I mean it is proactive.

Senator BOYCE—But they are all operating within a similar framework at the moment.

Mr Frank—They can operate under the same umbrella, but it needs to be configured differently. If you configure it as they have in bill B—such that this is complaint driven—then I think it is unfortunate to run it that way. It is better if they have some kind of notion of notification or reporting. There are a number of different ways that can be expressed. It can also sit separately from the standard complaints process. Once you start the performance review, you may find that there is, for example, a substance-abuse problem, cognitive-impairment problem or health related issue, in which case you can then channel them across to the appropriate pathway and have them handled in that pathway. But the key thing about performance assessment is that in some cases the performance actually does not identify a mad, bad or sad practitioner—it identifies somebody who is out of touch with current clinical practice—and a remediation program can get them back onto track and get them back into the setup. There is no stigma of a complaint attached to that; it is just maintaining the professional standards and continuing professional competence of a health practitioner. We feel that if that could be separated—as it is, for example, in the legislation in New South Wales and, I think, also in Victoria—it would be a much more effective way of handling this particular issue. If they lock it into the complaints process then it defeats one of the key elements of having people voluntarily participate in these sorts of programs.

It is interesting that the most significant of these programs internationally is the one that has been set up in Canada, where all the provincial licensing authorities have combined their resources to set up a single program. That program is called the physician performance and enhancement program. It is built and configured as a risk management and maintenance of professional standards program. I think that is the clue. They have done more work in that field than probably anybody else. In Australia New South Wales has been doing this for nearly 10 years and Victoria has been doing it for eight or so. A lot of expertise has been developed in this area. It would be a shame if we then moved back to what existed prior to setting up these performance pathways.

Senator BOYCE—So you are proposing that we have a proactive and a reactive stream within the system.

Mr Frank—Absolutely.

Senator BOYCE—Thank you.

CHAIR—My only question is around the code of good medical practice that you have mentioned and which was also mentioned by previous witnesses. In terms of that process, we had extended discussion about the difference between having a code that was approved and having mandatory reporting. Did you have any comments on that?

Mr Frank—I think they are two slightly separate exercises. You can have a code without having a mandatory reporting system.

CHAIR—Absolutely.

Mr Frank—I think the code represented the work done by a number of the medical boards over a number of years. We knew that the national registration scheme was coming, so we thought it was useful to try to pull together the key elements of the existing codes into a single document. An enormous amount of work went into that document, and we thought it looked pretty good—until we put it out to public consultation and had it torn apart by everybody. I will come back to that in just a second, because it is really very—

CHAIR—It happens to everyone.

Senator BOYCE—There is very good modelling of the behaviour!

Mr Frank—With funding support from the Commonwealth we were able to undertake a very large consultation process. We were able to suballocate some of that funding to the Consumers' Health Forum of Australia so that they could actively participate as well. The mark 2 version of the document bears scant resemblance to mark 1. It is a much better document; there is no doubt about that. The other interesting thing about it is that it is clear that this is an area that is not a static event. Clearly, as we develop this document in time, that document will need to continue to develop. What is important about the process, though, is that in a number of places in bill B it talks about extensive public consultation on accreditation standards and on registration standards. Looking at the cost, the complexity and the energy and effort that went into that one document, I would suggest that the three-year timeline they have put in bill B for these consultations to take place is unrealistically short. I think there is also a danger of starving the resources.

I am assuming that health consumers are going to be involved in pretty much all of the 10 health professions in these consultations. We had to work very hard and they had to work very hard to get just the one code of conduct thing through, so I think that a lot more planning has be done. Perhaps that is an area for joint work to be done with all of the health professions involved in the new national arrangement to see if we can come up with a smarter solution and maybe a more resource-efficient way of dealing with those consultation processes; otherwise, if each of us have to do this individually for all of our accreditation processes and for all of our registration processes in all health professions, there is going to be a continual consultation process going on over the next three years—and then some.

CHAIR—What is the status of your draft code now?

Mr Frank—It has come back. We have one a second, smaller-scale consultation with some key stakeholders. It is being rewritten. The it will get presented to the council. From the council it goes to the national board when that is established.

CHAIR—Is there an expectation that this code will be part of the national scheme?

Mr Frank—Yes, but we do not know how. That will be a matter for the board.

CHAIR—Because it is not in the bill, is it?

Mr Frank—No.

CHAIR—So this process has been going on in a complementary fashion.

Mr Frank—Yes. The bill talks about national boards being able to establish codes and guidelines. We assume that it will be a guideline, not a mandated code in the sense that strict adherence would be required or you would be in breach of professional standards et cetera. It is more likely to be a code that is used as a guideline by the various state and national bodies to deal with particular issues, but that really a matter for the national board to determine. We can put it to them, but they will be the ones who will make the final decision on that one.

CHAIR—And it is only looking at doctors at the moment?

Mr Frank—Yes. We understand that some of the other health professions are looking at. It has been through the consultation process, and there were some interesting things that came out of it. That is entirely up to them. We have no problems with that. It is a public document, if they want to take it and use it. We built on other peoples' documents; there is no problem with anyone building on ours.

CHAIR—Does your council have any view on mandatory reporting?

Mr Frank—No. We are not directly involved in registration issues, so the only aside issues we hear is that in some states—for example, New South Wales—it has not significantly altered the information coming up the line. In other words, they have not been inundated with reports. I know that there are lots of issues around how things should be reported and what is reportable and there may need to be some finetuning of some of those definitions. I understand that the individual medical boards are making submissions on those matters, but it is a bit beyond the charter of the AMC to really comment on that.

CHAIR—I know I should have, but I have not read your code yet. Does the code refer to the responsibility of a doctor to report another doctor who is—

Mr Frank—It does cover it, but it covers in a guideline form rather than in a specific form, because we know that that is something that can be covered by individual legislation.

CHAIR—You have seen the ministerial council's recommendation that has now gone into bill B, which has significant harm to the public as the threshold.

Mr Frank—Yes.

CHAIR—That is an interesting thing in itself. We had some discussion with one of the earlier witnesses from the medical indemnity profession about the various cases for mandatory versus internal development of a better environment—and those discussions go round and round.

Mr Frank—With the bill you have two things, one of which is somewhat new for most of the jurisdictions, and that is the public interest assessor. The other one is that, if the bill can be made

more flexible so that there is a capacity to triage at the front end, an issue that might come up through a mandatory report can then be channelled into the appropriate areas and handled reasonably quickly and in a way that does not mean that they all have to come back as a formal conduct or complaints process.

A sizeable number of the complaints that come up to medical boards—something like 70 per cent—relate to communications issues. That can be a personality issue, a substance abuse problem or impairment that is driving it—it can be all manner of things. In a sense, they have to look at these things because, even with something like the use of bad language which might appear to be innocent enough, when you actually drill into it you might find that it is a clue to somebody who has problems elsewhere. That is where your performance pathways, impairment pathways and other pathways come into it.

CHAIR—If there are no further questions, is there anything, Mr Frank or Ms Menzies-McVey, that we have not asked you about that you want to put on the record?

Mr Frank—I might leave for the Tasmanian senator, a copy of the original act—just purely as a historical record. As I said, we keep reminding the Brits of it, and they dislike us intently for it.

CHAIR—Thank you very much for your evidence and your ongoing evidence to this inquiry. We appreciate it.

[11.38 am]

MUDGE, Professor Peter Rowland, Chair of Council, Royal Australian College of General Practitioners

WILSON, Dr Gregory James, National Policy Advisor, Royal Australian College of General Practitioners

CHAIR—Welcome. You have information on parliamentary privilege and the protection of witnesses. We have your submission—thank you very much. It is extraordinarily extensive; it is a huge submission. I invite either or both of you to make some opening statements and then we will go to questions. One question, though: does your submission predate bill B?

Dr Wilson—Yes.

CHAIR—So there may be some changes?

Dr Wilson—Yes.

CHAIR—I always like to check at the start because some people have given us different things. Your submission is dated 30 April. Since then we have had the bill B exposure and the ministerial meeting.

Dr Wilson—That is right.

Prof. Mudge—I will start. I am the chair of the national council of the Royal Australian College of General Practitioners. The president sends his apologies. He was summonsed to the minister's office today, so he is on another mission.

CHAIR—Ah, we know where we fit then, Professor.

Prof. Mudge—I am the default option. For people who may not know, the Royal Australian College of General Practitioners is 20,000 members strong and we are responsible for the standards of general practice across Australia and maintaining the standards. We are involved in the examination process for fellowship and for the awarding of specialist status for those general practitioners who successfully achieve a fellowship of our college. We are also responsible for the training of IMGs in this country, which is an important focus, I know, of this inquiry.

Thank you very much for the opportunity to appear before the Senate and to provide our input. After reviewing the exposure draft of bill B and attending meetings in Victoria, Tasmania, Queensland and New South Wales regarding the national registration and accreditation scheme, the college is pleased that some of its concerns and some of those of the medical profession have been taken into account. It is pleasing that, following the feedback process, there have been undertakings to make a number of substantive changes to the exposure draft of the legislation. However, the college remains extremely concerned about the lack of real support for our international medical graduates in this country.

The college is keen to work with government and with the National Health Workforce Taskforce in sorting out the issues in order to ensure that the legislation accurately reflects the intent of the proposed scheme, which is to maintain a healthcare workforce in sufficient number and of the highest standard to serve our patients. We await the materialisation of our suggestions in writing. In particular, we are keen that there is a recognition of the Australian Medical Council and its role in accrediting medical education and training; secondly, that there has been significant movement towards registration and accreditation being independent of government; thirdly, that there is recognition of the medical colleges and their roles in setting the training and continuing professional development standards for their profession; and, fourthly, that medical student registration has been included in the legislation. All these matters, as you are aware, were in our submission.

CHAIR—Yes, and each of those issues was raised in previous evidence by various groups.

Prof. Mudge—As mentioned, we are keen to work with the government on a number of issues which we believe need further improvement in the legislation. I would like to go through a number of our concerns and provide solutions and alternatives to what has been proposed so far in the exposure draft of the legislation. Firstly, I will go to the issue of independent accreditation. Clause 10(4) of the draft exposure bill B states that the ministerial council can change an accreditation standard if it believes there will be a substantive negative impact on 'workforce'. This wording could be construed to be very employer centred and to be designed mainly to augment workforce numbers at the expense of quality and safety. It is the view of our college that policies like these have landed the jurisdictions in a lot of trouble in recent times, and it is troubling to see that the COAG draft legislation currently seems to perpetuate this risky situation. This is exactly the type of overarching power that the college has repeatedly said it would be concerned about.

The college can understand that in extreme and extenuating circumstances the government may need to intervene on an accreditation standard. However, the draft wording puts no limits on the powers of the ministerial council. Furthermore, the emphasis of decisions to be made rests entirely on the grounds of workforce, which can only be construed to mean workforce numbers, while completely ignoring the equally important issues of standards and safety of the public. The wording of clause 10(4) should be amended to clearly state that it is the quality of health care and patient safety rather than issues of workforce upon which the ministerial council will intervene.

The second point I wish to make relates to the matter of ministerial council transparency. We note that the exposure draft of the legislation says that the ministerial council has the final authority on a number of accreditation, registration and standards issues and policies. Ultimately, this would mean that the ministerial council can at its discretion reject standards recommended by the health boards and councils in relation to registration. It also means that, ultimately, the ministerial council could reject standards recommended by the health boards and councils in relation to accreditation. While there may be requirements on rare occasions that this type of decision may be necessary, it is important that the process is public and transparent. Therefore, we strongly recommend that both the recommendations of the health boards and the reasons for rejection of the decisions by the ministerial council should be made public.

Another feature of bill B is the public interest assessor. Clauses 35 to 38 in the exposure draft describe the role of the public interest assessors, who will be independent of the national boards. Whilst there is clear merit in such a position, we strongly believe that the public interest assessors' role should be better defined in the legislation, including the extent of their powers. Given the high level of responsibility of the role and the inevitable scrutiny which will come from both patients and the profession, we also believe that, if the legislation is to include the role of a public interest assessor, persons occupying the role should only be appointed for finite terms—which should probably be limited to a maximum of two years. Lastly, we also believe that it is imperative that the public interest assessor is supported in their role and they should be required to consult with experienced and knowledgeable health practitioners and consumer representatives on important issues and cases.

I would now like to speak about mandatory reporting. Clauses 156 and 157 in the exposure draft describe the proposed mandatory reporting arrangements. It is disappointing to see that mandatory reporting has been included in the legislation despite the well-considered feedback provided. We have previously advised the National Health Workforce Taskforce that mandatory reporting is a multifaceted and complex issue and we have called for further discussion and consultation. The issue is that mandatory reporting is likely to have the opposite effect to that intended. The legislation as it currently exists will cause medical and health practitioners to hide their impairments and professional issues from their colleagues, driving the issues underground and increasing rather than decreasing the risk to patients, the public, the practitioners themselves and their colleagues. We strongly believe that it is important to strengthen patient safety and improved standards; however, the mandatory reporting system as currently proposed is not, we believe, the solution.

The college is pleased that medical student registration has been included in the exposure draft of the legislation; however, we believe it needs to be made clear that an undergraduate health student must be registered as soon as the start seeing patients, regardless of the level of supervision.

As to the use of specialist titles, the RACGP believes that it is imperative that the public can identify the difference between a qualified medical specialist who has passed the assessment requirements for their medical speciality and a medical practitioner who is working in an area of need whose qualifications have not yet been determined to be substantially comparable. Therefore, we recommend either that all medical specialists use the title 'specialist' or that medical practitioners working in an area of need clearly define themselves, in a non-derogatory fashion, as not being a specialist—for example 'area of need general practitioner'.

With regard to limited registration, the exposure draft of the legislation currently states in clause 90 that health practitioners who obtain registration to work in an area of need can only obtain limited registration for not more than two years. The college believes very strongly that this is not a sufficient length of time and that four years would be more appropriate.

On the subject of continuing professional development, the RACGP is pleased that continuing professional development has been incorporated into the legislation at clause 101 and that the ongoing roles of the medical colleges in standards setting and delivery of CPD have been recognised. However, it was interesting to hear in a recent meeting with Dr Louise Morauta in Melbourne on 8 July that there is a mistaken belief that the RACGP does not make available its

continuing professional development program to non-member GPs. For the record we advise that as of April 2009 we had over 8,000 non-member medical practitioners enrolled in our QA and CPD program. Medical practitioners do not need to be a member of our college to enrol in continuing professional development and, therefore, this will not pose an issue for the implementation of a health practitioner regulation national board. That concludes my formal introduction.

CHAIR—On that last point, that was just in discussion; it did not have any impact. The continuing professional development is now incorporated as a core part of the proposed bill, isn't it?

Prof. Mudge—Yes.

CHAIR—So it was just a misunderstanding about whether your services were available.

Prof. Mudge—Yes.

CHAIR—It is good to have it on record, because I knew that your services were available to nonmembers.

Senator HUMPHRIES—Could I ask you about this issue of the power of the ministerial council to reject standards on the basis that they do not deal appropriately with, or they threaten to exacerbate, workforce shortages—whatever the terminology is in the bill. I note that you said that in rare cases such a power ought to be available, but you are concerned about the potentially wide ambit of the way that the clause is drafted and you want some protection that ministers will not effectively force lower standards on doctors, for example, by pushing this issue further than it is intended to go. I note that your suggestion is that reasons for a rejection of a standard by the ministerial council should be published. That is a very good suggestion, may I say. In terms of tightening the wording of that clause to make the power more limited, I have asked a number of other witnesses to suggest other forms of wording and, with respect, I have not seen anything particularly convincing as to what you would do to capture that spirit of only a very exceptional kind of operation of that clause. Do you have any suggested wording as to how that clause should read in order to make sure that it is only operating in those rare cases you are referring to?

Dr Wilson—We are talking about 10(4); is that right?

Senator HUMPHRIES—Yes.

Dr Wilson—In a way it is almost worth making it broader. I think that trying to nail it down to standards, or nailing it down to a public good test—I know the AMA is interested in that—or nailing it down to workforce is in a sense always going to exclude another good reason for doing it. If it were more inclusive or broader and, also, on the same action made more transparent, I think everyone would be happier with the way that that clause operates. So, if you can include all the suggestions that you have had, my suggestion would be that that in a sense is a way of narrowing it, because the more you try to define any terms of reference the more people have to fit into what is actually said, and the narrower that is the more leeway they think they have.

Senator HUMPHRIES—I think you make a good point; it is impossible to define in advance the circumstances where you might need to exercise this power. The best backstop against it being abused is simply the public nature of the exercise and the legitimate tension that would arise if a ministerial council tried to impose lower standards for the sake of some politically expedient reason.

Dr Wilson—Absolutely, and we have seen that with the investigation of the College of Surgeons. It was very much a fact that one of the best outcomes was that now the college is extremely transparent with its training programs and its standards setting. The ACCC, the AMC, the jurisdictions and the hospitals are happy with them; they are now working in partnership. It is too adversarial. We need to get over that and do what the surgeons did with everybody and put the patients first. Almost every clause should have the word 'patient' in it. It is about the patients and sometimes it is going to be numbers of practitioners and sometimes it is going to be, 'The standard needs to take precedence here; there is a problem.' As long as we work together; that is what we read into *Hansard* and that has been the tenor of all of our submissions.

Senator HUMPHRIES—Could I ask you additionally about the role of state and territory registration boards. You raised some concerns in your original submission about this. Do you think that bill B has got the balance right with respect to the role of state and territory boards?

Prof. Mudge—I actually wear two hats: I have to warn you that I am Tasmanian and I listened to the debate about Tasmania and I belong to the Tasmania Medical Council. I listened to Dr Morauta's, and her department's, discussion of this in Tasmania 10 days or so ago. I think that there is a very much clearer role for the medical councils than there was in the early discussions, and from that point of view I think the profession is comfortable about it. Certainly, the college does not have a comment about that at this stage. If it is going to be in a sense business as usual for the jurisdictions operating as branch offices of a national arrangement, the really important local issues—for which Tasmania was used as an example in your previous discussion—are going to be very important. That seems to me to be preserved in the new draft.

Senator HUMPHRIES—Speaking as a local representative on one of those boards, do you think that the structure of bill B with respect to interaction between the national board and the state and territory boards is going to be a dynamic one? Will it allow feedback to pass between the two? Will members of a board like yours be able to say to the national board, 'Look, you need to give some attention to this,' or 'This issue is not working well in Tasmania; take a different tack'? Is that structure in bill B really an effective relationship in your view?

Prof. Mudge—It is going to have to be tried to see whether it will. Those structures already exist. As you know—

Senator HUMPHRIES—Not with a national board they don't, do they?

Prof. Mudge—Not with a national board, but there are already structures for those groups to come together and to have communication, one with another, and it is simply a matter of that being welded into some sort of national body, which must be proactive. My personal opinion is that that must be a step forward in the way we do business because it is just a tangle out there at the moment, as I am sure people have made clear to you.

Senator HUMPHRIES—Is it possible under the structure of bill B for a member of a state board like that to also serve as a member of a national board?

Prof. Mudge—I cannot pretend to have read it in that close a detail, but nothing that I have heard discussed about it suggests that that is prohibited. Some members of our board in Tasmania have applied to join the national body despite the apparent exclusion of Tasmania from the list of people who are going to be on the board.

Senator BOYCE—I am sure that was one of the errors!

Senator HUMPHRIES—It may or may not be a good situation to have people serving on both levels. It would be a good communication conduit of course but it may also possibly be a conflict of interest in some situations.

Prof. Mudge—There is a terrific amount of correspondence between states at the moment. I am sure our registrar from Tasmania would complain that a lot of her staff time is taken up with double-checking people who want to register in Tasmania with other states and trying to track them down at their previous place of work and so on. That will all become much simpler with the national arrangement. As you know, the college has been strongly in favour of that from the very beginning of this debate.

Senator FURNER—I would like to go the matter of mandatory reporting, which you raised in your submissions. You indicate that there are some issues with the definitions. On my viewing of those definitions, they seem reasonably universal. Could you elaborate further on the concerns you have raised about the proposed definitions being 'too general to be effective'.

Prof. Mudge—I will ask our policy adviser to answer that question.

Dr Wilson—I am just looking up my submission. Did you specifically mention—

Senator FURNER—They are on page 10 and at 3.3.2. That is in the first lot of submissions.

Dr Wilson—Sorry; do you have the appendix number?

Senator FURNER—They are in your submission dated 30 April 2009, on page 10.

Dr Wilson—Sorry; I was looking for the appendix. I have it. Which definitions?

Senator FURNER—You have listed unsatisfactory performance and misconduct as examples where the definitions are too general.

Dr Wilson—The issue, from our members' point of view, is: are they going to be confident to report somebody if they do not know exactly how deep the trouble that they are getting them in is and whether it will be a punitive process or a supportive process. It is always about knowing when to report. That is the problem. For example, what is substance abuse? You have the good Samaritan problem where someone works in a rural area, they have been golfing, they have been there for two hours, they have stopped at the 19th hole and suddenly a call comes in and the other bloke is already busy, so she has to run in. There are those kinds of issues. Should a person

be reported for coming in after three glasses of wine when there is no-one else? Where is the boundary for substance abuse? Another one would be: should a medical practitioner report a colleague for a mental health problem which may be either temporary or permanent in nature? Where is the borderline?

It is really about defining not so much the type of issue but the extent of the issue, the time at which it needs to be reported and then whether they are going to be encouraged to report based on the response that is going to come down. Those are the issues and, as a membership based organisation, we know that they are actually big issues. Our feeling is that it has not been properly considered in the consultation process, that we have not had any feedback and that there has not been evidence in the draft exposure bill that anything the profession has said has made a lot of difference in that sense.

Senator FURNER—So is it a case of clarity around what would happen in circumstances similar to those you have raised rather than the intent of the definitions?

Dr Wilson—It is both. I know that Mr Frank brought up the issue in the AMC evidence that was just given that it is partly about what the response is going to be. The fact is that we know the AMA has the same issue and that a lot of the large bodies representing the medical profession have that issue.

But it is also about knowing when to report. There are some very clear instances. There are going to be some clear instances where there is long-term serious addiction to narcotics or something like that or where there is deliberate harm. If that sort of thing comes to light, that is clear. But those sorts of things happen anyway. What is this legislation going to add to make the public safer and how is the legislation going to provide support for both the reporter and the practitioner being reported?

Senator FURNER—I want to concentrate on the scenario you used about a GP out on the golf course. Having consumed, let us say, three glasses of wine in the space of a couple of hours and then having responded to an emergency call, no doubt there is some issue associated with the operation of a vehicle on the roads. What requirement, if any, is there for that GP to be under a suitable level to tend to an emergency in the practice?

Dr Wilson—They have to have their time off. I think the issue would be if they were on call; then there would be a case. If they were not on call then there would have to be all kinds of flexibilities in the system. A nurse would come to get them, they would not be allowed to use a knife—that kind of thing. Someone has to be there who is still relatively cognisant and who has the knowledge and the skills to at least take control of the situation and not cause harm.

Senator FURNER—Earlier today, we heard from the Medical Indemnity Industry Association of Australia. They certainly had an issue with mandatory reporting but then went a further step, indicating that if we had to have mandatory reporting they would consider some limitations based on practising while intoxicated by drugs or alcohol or based on sexual misconduct in connection with the practise of medicine. What is your view on those limitations? Do you think those are reasonable, or should there be more?

Prof. Mudge—I believe our college would consider that to be quite reasonable. They are clearly still areas which are offensive in the law. Anything that is offensive in the law would be seen by our membership as being inappropriate. The difficulty is the drawing of the line, as Greg has talked about. There are lots of anecdotes that go, 'I was a country GP for 15 years and you are always on call.' There are always difficulties about that, and common sense has to be used. But our membership, I am sure, would be united behind the idea that anybody who was guilty of a lapse with respect to alcohol and sexual advances with patients would come before the Medical Council. If it did not then mandatory reporting would be seen as a reasonable step in those sorts of circumstances.

Dr Wilson—Sexual boundaries absolutely come under the category of deliberate harm.

Prof. Mudge—If the patient's safety is going to be affected by whatever the activities are, that ought to be the basis for a reporting of that incident.

Senator FURNER—One last question. The previous witness indicated that around 70 per cent of matters reported were communication issues. I think you were in the room. I wonder whether you concur with that view and whether you would like to elaborate further on that.

Prof. Mudge—From the college membership point of view I do not think I can comment on that, because I do not think I have seen any data about that. But certainly it is true that in disputation with patients at the coalface of general practice it comes down in the end to a failure of communication one way or the other in the vast majority of cases. In that sense, I think we could agree with it.

Dr Wilson—Certainly the continuing professional development modules provided on medicolegal issues would tend to support that. The kinds of figures that they quote would be that at least 50 per cent of medicolegal issues arise because of failures of communication: 'The doctor ignored me;' 'The doctor was rude to me;' 'The doctor didn't tell me properly what my medications should be;' and that kind of thing. It is a communication problem more often than not.

Senator BOYCE—I want to follow up on appendix 2, which is from February 2009. You have a section in there talking about the lack of meaningful stakeholder engagement. You say:

The College is concerned therefore that the "consultation" process puts public clinical safety at risk, by not properly considering the views of the medical profession …

Is that still your view?

Dr Wilson—I think that when the draft bill came out it was the first evidence we had that we had been listened to.

Senator BOYCE—You are talking about bill B?

Dr Wilson—Yes—draft exposure bill B. Until then, there had been no commitment in writing in any way, shape or form, in any COAG communique or anything else, that we had been listened to. That was a professionwide concern, but the actual content of draft bill B and the

consultation process that has been happening around the different jurisdictions since then has allayed a lot of our fears.

Senator WILLIAMS—One last question: in relation to the delivery of health services, it is a general attitude of GPs that they do not have a lot of confidence in chiropractic treatment? I just thought this was an opportunity to ask that question. If you would prefer not to answer, it does not matter!

Prof. Mudge—I am happy to answer in a general sense. One of the challenges for the healthcare professions is a better understanding of the individual roles that each of us holds and of a better way in which we can combine our roles for the health of our patients. This is the primary healthcare model, which is the subject of another inquiry that is going along parallel to all of this. The college of general practitioners is very keen to see the development of effective healthcare teams who can provide whole-patient care for patients in a coordinated way. At the moment, it is uncoordinated, extremely costly and sometimes not very effective, and it is often based on a lack of understanding between the individual roles of the healthcare providers—all of them. There is some hostility between each. The pharmacists think the doctors do not know anything about drugs, the orthopaedic surgeons do not think chiropractors know anything about backache and so on. I think that those rivalries have occurred in medicine through the whole of its history from the 15th century and will not go away. But we are in a position where we can produce efficiencies and effectiveness in the continuity of our care of our patients by being cleverer about primary healthcare teams, providing health to the patients where they need it and keeping them out of hospitals. It is not rocket science; we could do it if we had the will to do it.

Senator WILLIAMS—I am glad that you had trouble reading your writing; I have seen some GPs' prescriptions over the years, and I think some of the chemists really do have a good knowledge of written English!

CHAIR—Thank you. We appreciate your evidence, your submission and the ongoing support that your organisation gives to our committee.

Prof. Mudge—Thank you very much.

Proceedings suspended from 12.14 pm to 1.03 pm

PESCE, Dr Andrew, President, Australian Medical Association

SULLIVAN, Mr Francis, Secretary General, Australian Medical Association

CHAIR—I welcome witnesses from the Australian Medical Association, Mr Francis Sullivan and Dr Andrew Pesce. Dr Pesce, I note that this is the first time you have appeared before the committee in your new role so congratulations. My understanding is that in this part of the hearing you will be talking about NRAS, the national registration and accreditation scheme. Is that right?

Dr Pesce—Correct.

CHAIR—And then when you come back later you will talk about Medicare and so on. Is that right?

Dr Pesce—Correct.

CHAIR—You are both very experienced at appearing before parliamentary committees so you understand about privilege and protection. I always enjoy hearing your title, Mr Sullivan. Every time you say it I enjoy hearing it. In terms of process, if either or both of you have an opening statement we will complete that and then go to questions. Senators will be coming in and out of the hearing as we go through. There is no lack of interest in this topic.

Dr Pesce—The AMA is pleased that the Senate committee is considering the proposed national registration and accreditation scheme. It has been quite a significant issue for the AMA and the medical profession for quite a number of years. There is no doubt that this committee inquiry has helped change the focus that has been placed on this proposal, and I thank the committee members for their consideration of the matter. I would like to clarify that the AMA supports a national system of registration for doctors. We want to ensure that only suitably trained and qualified medical practitioners are able to practise. We also want to make it easy for these doctors to work across state and territory boundaries without having to re-register.

The AMA's fundamental concerns with the proposed scheme have been around the independence of the arrangements for the accreditation of medical education and training. As a result, we were concerned that the high quality of training for doctors in this country could diminish. The medical profession currently has an autonomous process for developing and setting accreditation standards and for accrediting medical courses. This process enjoys the highest level of professional expertise and input and is free from political and bureaucratic interference. As a result, Australian trained doctors are of the highest quality in the world.

Our primary concern with the scheme has been that the ministerial council would be able to put workforce supply and budget imperatives ahead of high medical standards. We were worried that political influence on accreditation standards could be driven by the need to address workforce shortages. We wanted to ensure that there could be neither fast-tracking of medical practitioners with lower skills and experience into the workforce nor that underqualified medical

practitioners or non medically trained health professionals could work beyond their scope of practice and training.

We were concerned that this could introduce risks to patient safety and quality care in the Australian healthcare system. At a broader level, we were also worried that international recognition of Australian medical education and training would be compromised because it was not independent of government. The current bill has addressed some of our concerns about accreditation and I would like to highlight them for the record.

First, the accrediting body will accredit the education and training courses and in a separate process the board will approve courses for registration purposes. This separates the accreditation function from registration. Second, we are happy that the existing accreditation standards for medicine will be adopted on transition to the new scheme. Lastly, changes to the accreditation standards will now be approved by the medical board and not the ministerial council. This can only happen after the changes are recommended by the accrediting body. In the case of the medical profession, this will be the Australian Medical Council at least for the first three years.

In summary, in bill B neither the medical board nor the ministerial council can unilaterally change accreditation standards. However, the ministerial council has retained a power to issue policy directions to the board on accreditation standards; and it is on this aspect that we have reservations. This power is contained in clause 10 of bill B. We would like to see greater codification in this bill of the circumstances in which the ministerial council will be able to use this power. We would like to see additional mechanisms to make their use of the power more transparent.

Our submissions sets out the additional provisions we believe should be included in the bill. These are needed to protect the independence of accreditation standards to ensure patient safety and quality of care remains paramount. We also believe the medical board, and not the ministerial council, should be responsible for appointing external accreditation bodies. Our concern here is that under the arrangements in the bill if the ministerial council is not satisfied with the recommendations that are made by the accrediting body then the ministers can summarily replace it.

We do have a range of other issues that we believe require clarification and perhaps further amendment. This is not unexpected with an undertaking of this nature. Most of these issues go to the functional operation and administration of the scheme. These are set out in the second part of our submission, which we lodged with the committee yesterday. I would also like to make the point that this scheme will only be a truly national scheme if consistent legislation is passed by each jurisdiction. There is a lack of clarity from state and territory ministers on a number of issues about the debate of the bill which will be handled in each parliament—firstly, whether each minister will insist that their parliament passes nationally-consistent legislation; secondly, whether they will accept any changes to the bill to meet local circumstances beyond those areas where the framework currently allows them to do so; and, thirdly, whether the bill will need to be changed to enable state parliaments to have sovereignty over future changes to the legislation, and not have changes passed only in the Queensland parliament.

In closing, I want to be clear that there is nothing in the proposed scheme that will improve the protection of the public from isolated cases of harm. To think that any legislation or additional

bureaucracy will do this is naive. In this respect this proposed scheme will be no better than the current arrangements that are in place, but it will cost more because it has more administration attached to it. An example of this is the public interest assessor, which has been introduced without specific consultations. We need to know more about exactly what, how and when it will carry out its role. It is expected that the professions registrations fees will cover the cost of the public interest assessor, and that is something we object to. Protecting patients from harm requires better resourcing of our health services and better professional support and guidance on the ground for the health professionals who provide services to patients every day.

CHAIR—Thank you. Mr Sullivan, if you have nothing to add, we will go to questions.

Senator HUMPHRIES—Sorry for being late. Good to meet you, Dr Pesce.

Dr Pesce—It is like an obstetrician turning up just in time!

Senator HUMPHRIES—I will not go there. I cannot find the question I had written down to ask, but I was going to ask about the view of members of the AMA of the structure of the registration and accreditation requirements. We have had continuing evidence about the extent of their independence from government, and the case has been put to us by various witnesses that there is still too much power for the ministerial council to interfere in the setting of registration and accreditation standards. Essentially, what is the position of the AMA with respect to that power? Is it necessary? Should it be constrained in a greater way than it is in the current bill B?

Dr Pesce—We believe that it is important to separate accreditation from the political process. There are a number of reasons for that. I guess the main one in the back of our minds is the potential for a conflict of interest to arise out of a minister who is responsible for providing services in his or her jurisdiction and for proper accreditation standards placed for the training of practitioners in that area. Obviously there can be a tension for a minister who is under political pressure to provide services and, therefore, to possibly make some decisions to help provide those services—decisions which might ultimately compromise an independently arrived at, arm's-length process to make sure the quality of the courses is satisfactory. I think that everybody recognises why the ministers want to retain the power—because they do have those responsibilities—but we believe it is very important that as much as possible that process be set at arm's length. To cut to the chase of what was in our submission, where ministers do wish to retain and exercise a reserve power to make determinations or to give directions to the board regarding accreditation standards, there should be accountability and transparency of that to make sure that it is quite clear what the public interest is and to make sure that it satisfies those standards that we want to see. It is not just workforce; it is quality and safety. Our position is that we believe that the accreditation system in place is an excellent one. We would probably ideally prefer that the ministers not exercise those powers. Our very strong position is that if they do have those powers and choose to exercise them there should be a very strong and transparent process for and accounting of why those powers are being exercised.

Senator HUMPHRIES—Even if you do not have a formal process of disclosure of reasons for ministers exercising that power—some witnesses have suggested that there should be that public disclosure—inevitably in these processes the politics of an exercise of that power would become very public. There would be public debate about that. Let us hypothesise a situation. People die in remote parts of Australia because they cannot get medical attention in time. The

health minister says: 'There is a crisis in regional and rural areas and so to deal with this problem we are going to allow doctors in their final two years of clinical training to go to those areas to practice as doctors in order to meet that shortfall. People's lives are the most important things to be looking at.' How do you think that would play out? Do you think there would be public pressure on ministers to stop doctors who are not yet fully trained going into the field? Do you think that there would be a backlash against that decision? How would that work out? Would the public pressure be enough to prevent an inappropriate use of the minister's power to lower standards for the sake of satisfying need?

Dr Pesce—I think it depends on how transparent that process has been. If there has been enough public debate and if there has been enough consultation with the medical profession about what the urgent need is by inviting us to discuss what the appropriate response would be—and if you have demonstrated a potential urgent need—I think that would be the ideal. I suppose one of the issues is that we need confidence that in this process people are not sometimes just taking the easy path towards solving a difficult problem. The example that you raised is a particularly difficult one, because we are talking about a remote area. I remember what I was like as a final-year medical student. I would be pretty nervous about going out there unless I had appropriate support. All of those things would have to be put in place.

I understand what you are asking and think that, in principle, those are the sorts of issues that might arise. That is why it is important to have transparency and accountability, and it would be much easier if, prospectively, we had an announcement from the minister involved, saying: 'The reasons I am considering this are this, this, this and this. I have had appropriate consultation with the AMA. I have had appropriate consultation with the medical colleges. I have had appropriate consultation with everyone. After exhaustive consultation, the only thing that I can come up with is this.' That puts it on a different footing rather than the minister just announcing, 'By the way, next week we're going to have medical students or someone else treating sick patients in remote and rural areas.' I think the effectiveness and success of this is going to be on how that consultation takes place and how it is seen not to be circumventing a difficult workforce issue with a quick-fix solution.

Senator HUMPHRIES—At the moment, though, there is no mechanism in the bill for consultation, is there? You would assume that there would be dialogue between the board and the ministerial council about what standards need to be relaxed in order to satisfy this crisis or whatever it might be.

Dr Pesce—I think there is a requirement that if, for example, there is going to be an expansion of the scope of practice of a group where it impacts on an existing scope of practice, there needs to be consultation with the board that oversees that specific clinical group. For example, if podiatric surgeons wanted to do surgeries on Achilles tendons or something, which is not in their current scope of practice, and if it were envisaged that it might be expanded, the submission would have to go to the medical board, who would have to have a look at that, presumably consult with the groups that are currently doing that work and see how that could be progressed.

Senator HUMPHRIES—When you say 'presumably', do you mean that is built into the bill or that it is inherent in the—

Dr Pesce—My understanding is that it is in the bill currently.

Mr Sullivan—Yes.

Senator HUMPHRIES—Okay. Does it define what those groups are or does it simply say 'relevance to the board'?

Dr Pesce—It is basically a generic statement saying that, if one of the boards wants to expand the scope of practice, it has to consult with the board where that practice is currently entrenched.

Senator HUMPHRIES—I will go back to have a look at the bill myself. I just could not recall.

Dr Pesce—It is clause 51.

Senator HUMPHRIES—Thank you. Finally, do you think that the mechanisms in the bill that allow for information to be exchanged between the state and territory boards and the national board for the new role that is envisaged for them is sufficiently robust and dynamic that local issues will be understood by the national boards? We have had some witnesses who have said to us that we should make sure every state and territory is represented on each national board. If you do not have that, the alternative is that you have a good feedback arrangement going on between the state boards and the national board. Which of those two models do you think is best, and do you think that if you were relying on the second you would have a good enough relationship between those two levels in the bill?

Dr Pesce—I think that ideally we would support each state and territory being represented. There is no doubt that the smaller territories and states, especially, are worried that the local issues that emerge in their own jurisdictions could get lost in a national process. It is not just in medicine; you see this all the time. There is no doubt that there have been a lot of representations made to me—including right up to now—about the importance of that. The main sensitivities are probably around the complaints-handling process. There is a worry that a national approach to this may not recognise problems that arise in individual communities. One that was raised with me was Indigenous health workers. It is pretty hard, unless you are actually in that area—working in those remote areas with completely unique circumstances compared to metropolitan city practices, for example—to be confident that the people who are making determinations on issues arising out of that would have enough local knowledge. There is no doubt that in the ideal sense we probably would support individual states and territories all being represented.

Senator HUMPHRIES—Okay.

Mr Sullivan—Madam Chair, would you mind if I added to some of the questions from Senator Humphries?

CHAIR—I do not mind.

Mr Sullivan—I am handing the clerk something. We probably need to put on the record our understanding of how accreditation and independence is working.

CHAIR—Is working or will work?

Mr Sullivan—In the bill.

CHAIR—So it is how you perceive the bill will operate.

Mr Sullivan—Yes.

CHAIR—Has this been given to Dr Morauta's accreditation and registration team?

Mr Sullivan—Only in consultations at this point.

CHAIR—Yes, we would like to hear on record how you perceive it is going to work.

Mr Sullivan—I will read through it. It is important, I think, because, as you know, there is independence of accreditation of specific courses and of education and training. That is one aspect of this. The bill makes it clear that only the accrediting authority—in our case, the AMC—can accredit individual courses. That is in clause 66(1). The ministers cannot interfere with the accreditation of individual courses of study. That is in clause 10. The board does not have any role in formally accrediting individual courses of study. The board only has a role in a quite separate process of approving a course as one providing a qualification, for the purposes of registration, after it has been formally accredited by the AMC. I am making that point because it is important for us to show that we have seen that there has been some shift around this issue that we have been pressing on the part of ministers. The second aspect of the independence of the accrediting body is around the setting of accreditation standards.

If the bill eventually goes through and we have a national system, on that transition the existing AMC accreditation standards will automatically be adopted under the new scheme without board or ministerial approval. That is in clause 290. In respect of future changes to the accreditation standards recommended by the AMC, the ministerial council can issue a policy direction to the national medical board where it believes the change that the AMC is recommending to an accreditation standard will have 'a substantive and negative effect on the recruitment or supply of health practitioners to the workforce' . That is clause 10. However, there is no capacity for ministers or the board to impose write or rewrite accreditation standards. Ministers can only issue directions to the board in specific circumstances and, in turn, the board can only approve or refuse to approve or seek review of a standard. That is clause 65. The ministers through the board can refuse to agree to a change in accreditation standards recommended by the AMC if it will have a substantive and negative workforce impact. This could cause a stand-off, but the AMC can publish details of its advice. That is clause 65. However, neither the ministers nor the board have any ultimate authority to initiate a particular change to the accreditation standards—for example, to lower the standards—because the legislation ensures that the only accreditation standards that can be operative are those that have at some point in time been recommended by the AMC.

Senators, I wanted to read that in because it is important for us to get clarification that our understanding of this legislation is correct. We assume it is and we have been told by officials that it is, but with bills and legal interpretations you always wonder whether the ice is thin or thick. We are operating on this understanding and, thus, the recommendations that we are putting forward to you today about how you can clarify those reserve powers of the ministerial council

are most important. Given that Senator Humphries asked the president what is our sense of this separation, that is it in writing.

CHAIR—Mr Sullivan, we will certainly ask Dr Morauta about that when she gives evidence, because this was the threshold issue of your previous evidence to this body. There are a number of other issues which you have touched on, but the threshold issue was the intervention or the perceived intervention of politics in the independent standards and the university status. That was stated very clearly. We will ask about that.

Mr Sullivan—Thank you.

CHAIR—I know that Dr Morauta has copy of what you have just read into the record.

Senator CAROL BROWN—You noted in the July 2009 submission that we have just received that there is some concern about the nomination process for board members. Do you want to expand on that for the committee? It is on page 7. It is basically self-nominating, as I understand it.

Dr Pesce—At the moment, after calls for expressions of interest are made, the boards are nominated and the ministers appoint the boards.

Senator CAROL BROWN—Did the AMA put in a preferred model during the consultation process?

Dr Pesce—I will have to check that.

Mr Sullivan—No, we did not put in a separate model. We were only making the concern, firstly, that a national medical board should primarily have medical people on it and that the people who are being put on it have the support of the profession. As the president said earlier, we would hope that the AMA and that the relevant colleges would be consulted so that there is some confidence.

Senator CAROL BROWN—I will go to the composition of the national boards. How is the AMA board made up? Is it by jurisdiction or state?

Dr Pesce—The AMA board?

Senator CAROL BROWN—Your board.

Dr Pesce—The board is the AMA Federal Council, which has a balance of geographic, craft group representatives. It is quite a large board—about 35 members. It has been considered for some time that it is probably too large. When the federal council is not meeting, the board is the executive—that is, the four members who are elected at national conference by the delegates. I suppose it is like the presidential primary system.

Senator CAROL BROWN—It is a bit like that.

Dr Pesce—They are the four elected members, and then two are voted up from federal council. So there are six executive members of the board who basically function as the board if the federal council is not meeting.

Senator CAROL BROWN—You have those elected members, and you have state and territory nominees.

Mr Sullivan—Yes.

Dr Pesce—They are nominated from federal council. Anyone can run for office, as I have just discovered.

Senator CAROL BROWN—The state and territory nominees are elected as well.

Mr Sullivan—Just to help out: the federal council has state and territory representatives, plus their presidents, and then the craft groups. So your point, I think, is: is there adequate and comprehensive geographic representation? The answer is yes.

Senator CAROL BROWN—I see. Do you have nominees on the council from any other jurisdictions, or is that it?

Mr Sullivan—As far as the geographic areas go, for example, we have a Western Australia representative, plus we have the representation of the AMA in WA, which is through their president—two. Tasmania, similarly.

Senator CAROL BROWN—You do not group South Australia and the Northern Territory?

Mr Sullivan—Yes, we do. We group South Australia and the Northern Territory into an area representative.

Senator CAROL BROWN—Okay. Who is the ACT group with?

Mr Sullivan—The Northern Territory and South Australia are grouped into one. The ACT is represented through its AMA ACT President, and the Tasmanians are represented through their AMA Tasmania President.

Senator CAROL BROWN—South Australia and the Northern Territory are grouped. Are the ACT and New South Wales grouped?

Mr Sullivan—There is an area person and—

Senator CAROL BROWN—And Tasmania stands alone?

Mr Sullivan—Tasmania is represented through its state president.

Dr Pesce—Every state and territory has representation on the federal council. I must say in relation to the process of determining committees and even the executive that a lot of thought goes into making sure that there is a balance so that there is representation.

Senator CAROL BROWN—It is a very large group. There was some commentary by the state president of the AMA in Tasmania about membership for Tasmania on the national board. In your consultation processes regarding NRAS, did you put forward a preferred model?

Dr Pesce—For national representation?

Mr Sullivan—Yes. Our preference would be that each state and territory would be able to be represented on the national board for the reasons we referred to earlier. A lot of local situations like the complaints and so on will eventually be handled; but, effectively, the complaints are being handled on behalf of the national board. It could follow in time that the registration and complaints handling functions for registrants in those smaller jurisdictions could be carried out outside the jurisdiction and, therefore, the whole sense of being responsive to local circumstance would be lost.

Senator CAROL BROWN—So, over time, it will move further away.

Mr Sullivan—There is potential for there to be a distancing in administration around, say, registration and complaints handling for smaller jurisdictions, particularly for those who will not have a seat at the board. In effect, the board is the entity through which these functions are administered.

Senator CAROL BROWN—Thank you for that. I also wanted to touch on your comments on the public interest assessor. Would you be able to give me your view?

Dr Pesce—One of the problems in giving your our view is that we have had very little information about it. It is something that has only been put on the agenda since the last ministerial communique. I do not think that it was even mentioned there. The first time that we were given any inkling that there was this extra responsibility considered was in when we saw the draft bill B. One of our problems in responding to you is that we have had very little consultation about what its intent is and how public interest is going to be reflected. We would be very interested to get more information about that so that we could have input into the process.

The other problem is that if there is going to be a national public interest assessor with its own office then that is going to cost money, and that is going to add to the cost if it is going to be imposed on the registrants. At this stage, our position is that we believe that if it is thought that that is in the public interest then that should be funded by the government not through the registration fees.

Senator BOYCE—I want to follow up on your comments about not having seen any information on the public interest assessor. We have had evidence from a few organisations who are concerned that this is their last chance to see bill B and that there will no opportunity other than when it gets to the floor of the parliament to comment further on any changes that are made. What is the AMA's position here?

Dr Pesce—We believe that we still need to have discussions about some of the administrative regulations and the rules that will surround the bill. But we also believe that this is probably the last chance that we will get to see the bill before it goes to the Queensland parliament. This has been a very long process. It has evolved over a few years. We understand that the process does have to come to an end. Basically, we would like to focus on those few remaining issues that we have highlighted. With that, we recognise that it has to go before parliament at some stage.

Senator BOYCE—As you have pointed out, this has had a very long evolution. The AMA's attitude to the legislation has also evolved in sync with the changes to it. You were certainly at one stage quite vehemently opposed to the intent of the legislation and were suggesting a far more minimalist approach. Can you talk through for me how the AMA has developed the level of comfort that you appear to have in principle at this stage?

Dr Pesce—As more and more information has come through, it has enabled us to reflect our concerns, with those correspondingly being incorporated into the development of the bill that we currently have before us. Senator Moore correctly identified that the threshold issue was on the independence of accreditation. It is probably impossible to make everyone happy all the time, and until it is seen in operation there will always be concerns. But we believe that, if our understanding as read into *Hansard* is correct, this gives us enough confidence that the independence of accreditation has been adequately addressed by the ministers in this latest legislation.

There are a whole lot of other specific issues to do with mandatory reporting. There have been commensurate responses when we raised the unintended consequences of making reporting mandatory in all circumstances—that is what it almost seemed like. We said, 'Although the intention behind that is good, you have to understand that there are times when the public interest is not met by that, such as where doctors may not seek help to address performance issues or personal problems because they are worried that they will get reported.' These are some of the things that we still need to progress, in terms of exemptions of certain individual people from the mandatory reporting requirements. There needs to be some sort of confidentiality between doctors who are self reporting to people who are supposed to help them so that they are not fearful that this going to have to be reported through the national process. There is still a lot of detail that has to be gone through.

Senator BOYCE—I was actually going to ask you at one stage about mandatory reporting. Do you want to talk about that now or do you want to just finish—

Dr Pesce—I am being told that I should read through a motion that went through AMA recently, incorporating these changes and recognising what our evolution has been.

Senator BOYCE—Okay; thank you.

Dr Pesce—At our last federal council meeting we noted the significant beneficial changes to the proposed implementation of NRAS by the Council of Australian Governments, ensuring that: the activity of accredited individual medical education and training courses of study remains the responsibility of the appointed accrediting authority, not the ministerial council and not the national medical board, effectively embedding the separation of the process of accreditation from registration; the learned colleges have an explicit role in providing advice to the ministerial

council on specialist medical training for the purposes of approving a formal list of medical specialties; the legislation explicitly prevents the ministerial council from writing or revising any registration or accreditation standards; the other health profession boards are required to consult with and report to the ministerial council the views of the national medical board on issues that might reasonably be expected to be of interest to the medical profession, including changes to scopes of practice by other health professions; there will be significant medical profession representation on the national medical board, including a practicing doctor being the chairman of the national medical board; state and territory boards of the national medical board can be established in order to undertake state administration of registration activity on behalf of the national medical board; there is flexibility in the complaint-handling arrangements to accommodate individual state and territory preferences; the national medical board fees and budget is kept separate from that of other health profession boards; while jurisdictional health ministers remain able to declare areas of need, there are express provisions protecting the right of the national medical board not to register applicants merely because they are seeking to work in an area of need; there is no requirement that medical registrants prove continuing competence for medical registration and the national medical board is able to determine that continuing professional development requirements of the relevant learned college are sufficient for medical registration purposes; professional indemnity insurance is required by all registered health professionals, not just medical practitioners; and, finally, provision of health workforce data by individual applicants is not mandated for the purpose of gaining medical registration or re-registration.

Senator BOYCE—Thank you—I can see why you resisted! Following up on that, before talking specifically about mandatory reporting, the suggestion was put to us today by the Medical Council that an acceptable solution to the problems around mandatory reporting would be to have a two-tier system where it was mandatory that the reactive complaints part was reported but there was the more proactive risk management and performance amelioration sphere of improving performance. Where does the AMA stand? The council were not comfortable that the requirements in the bill as it now stands were sufficient to allay fears.

Dr Pesce—I think that there is a recognition that the response to complaints would be best handled in the local jurisdictions by the states and that the proposed legislation left room for that. I think the AMA is quite comfortable with that. In terms of whether or not there needs to be federal coordination of this to ensure some overarching governance of that whole process, I personally would need to be convinced that that was necessary. If people think that is necessary, that is fine. In terms of whether the state response, the reactive part, has been insufficient, I would need to see what proposal there is to test the adequacy of the response and to demonstrate under what circumstances some other intervention was necessary. I guess that is what I understand the role of the public interest assessor might be. But, as I said, we have not even had any real conversations about that yet. We remain interested in seeing what the intention is and then giving our advice as to how that intention might be best reflected in the legislation and/or regulations.

Mr Sullivan—On the point of mandatory reporting, and just to add to what the President has said, there are some specific issues that we want to see addressed. We know that the medical defence organisations will submit, and they may have already done so.

CHAIR—They have.

Mr Sullivan—We would encourage you to take their counsel, because obviously we do. But for spouses, treating doctors and other professionals doctors such as doctors advisory health services they should be included in the exemptions to the mandatory reporting requirements in clause 156—and the draft bill should expressly preclude medical practitioners who participate in quality assurance activities, in accordance with the Commonwealth Health Insurance Act 1973, from any requirement to report reportable conduct identified during those activities. These are important things that we are speaking to the officials about going forward. I think you have probably heard from other health professional groups. They are suggesting the idea of educative scenarios to be put in place and provided to registrants so that they can have some certainty of what would be considered in the scope of reportable conduct before case law is established in this area, and we would support that idea as well.

Senator BOYCE—You run advisory or support groups, I suppose they are self-help groups, in all states and territories. Is that correct?

Mr Sullivan—I do not know if it is in all states and territories. The state AMA organisations do that, yes.

Senator BOYCE—So you do not have any information on the level of use of those?

Dr Pesce—They are very important structures. They are funded through the state AMAs. I know personally that where I work on two occasions we have felt that the best way to address certain issues with our colleagues was to encourage them to report to the relevant support service. In New South Wales that is very well recognised. It is funded by the profession through a voluntary subscription that we add on to our AMA fees and it is able to circuit break what is often a very tense and difficult situation where you are at work and you can see that there are some people with impairment issues. They are really worried that if it goes to a formal process with disciplinary type implications then they are going to be painted into a corner and they refuse to cooperate. Whereas you can pick someone who is reasonably close to that person in the workplace—someone who has their confidence that they are not just being got at. They take them to one side and say, 'Look, I think there are some real issues emerging here. Don't you think it is in your interest, as well as anybody else's, to have these issues addressed?' I have seen that work very well on a couple of occasions. I guess that is just a personal story. I am not sure we have a whole lot of evidence on how well that works systematically.

Senator BOYCE—We have had the view put to us that they are quite important but we just do not have any sense of the scale of the importance or the use of these programs. It has also been put to us that if bill B and the mandatory reporting it contains were to proceed as it is—despite the sort of fences that have now been put around it—then that could mean the end of those support services. What would your view be on that?

Dr Pesce—If it did mean that, that would be terrible. Whether or not that is a likely outcome I am not sure. I think the exemptions from mandatory reporting would be necessary. I can accept that—that if doctors feel that when they self report things to the body there is a requirement that that body notifies the medical board then it may well be that they will choose not to use that service in the way that I just explained. That is why those services are there in the first place: because they are seen as a different avenue to try to deal with problems before there is, potentially, some disciplinary process involved. So I guess it encourages self-help.

In certain circumstances self-help is very important; in others it is obviously not the appropriate strategy. But it is very important that we have that option, and I think the exemption from the mandatory reporting is necessary for that. If that was put into the legislation then I would be reasonably confident that those bodies could continue to perform the role that they are currently performing.

Senator BOYCE—I just wanted to ask you to explain something that you were mentioning earlier in regard to the states picking up this bill once it has been through the Queensland parliament. As I understand what you said, you wondered whether state ministers would have the power to change the bill to meet local conditions. Am I paraphrasing you correctly there?

Dr Pesce—Yes, that is correct.

Senator BOYCE—Can you explain your concern. Are you concerned that they will have or are you concerned that they will not have that power—and why?

Dr Pesce—My exposure to this has been pretty recent. I only assumed the presidency about six weeks ago but even in that time it has been difficult to get a coherent and single answer to the question, as the consultation process goes out, of to what extent—and we realise we are expected to have a national scheme supervising our practice—is each state jurisdiction willing to make the symmetrical compromises of its own jurisdictional independence. In various consultation sessions there have been mixed messages, to put it as best I can, as to ministers individual views on the extent to which they want to protect the sovereignty of their own state parliaments.

Senator BOYCE—Are you suggesting that not all states and territories are going to buy into this scheme?

Dr Pesce—What I am saying is that the message we have been given has certainly not been an unequivocal 'there is going to be one set of rules and we are all signing up to it'. As we get closer to this there have been messages put out there at various consultation meetings that some ministers may wish to ensure that their parliament has the ultimate say over what legislation is passed and what rules will apply in that state.

Mr Sullivan—Part of it is the certainty. We understand the process of an IGA, which is signed by governments, but now we are at the pointy end about national legislation and some of those governments do not control their state parliaments. So the question we have is on the degree to which we can have a reality that is a national scheme. As the President says, so far in the communiques since the IGA communiques—subsequently the health ministers have been making the communiques—there has not been an unequivocal statement that there will be passage of the bill in every state and territory as is appropriate to make it a national scheme. The second point we would like to stress again is that, as it currently stands, once all the legislation goes through the only way the legislation can be changed in the future is by passage through the Queensland parliament alone. We were wondering whether that will hold.

Senator BOYCE—That is a very good question. So what would give you comfort here?

Dr Pesce—I think we recognises the need for national uniformity and I think that at this stage of the game, given the fact we have gone so far down the road, what we need is an unequivocal

commitment from the ministers that they will stand fast and go forward in the spirit of the IGA which set up the whole process. It is very difficult to manage this whole process. The profession is a broad church. There are lots of individual groupings within the profession. You have the colleges, the councils and the specialty organisations.

Senator BOYCE—I think that nearly every one of them has been here as a witness.

Dr Pesce—To try and help you by giving a single response of the medical profession, we need to know that there will be a single response on the other side from the governments. You will have detected that this has been a fairly difficult issue for the AMA to manage. If the goalposts start looking as though they might be shifted for various political reasons—and I can understand why that happens—then it makes our role very difficult.

Senator BOYCE—You mentioned something about bills being changed to meet local conditions. Was that said in terms of any suggestions or conversations that you have had around that particular issue?

Dr Pesce—I will ask Francis to answer, because I was not at those meetings.

Mr Sullivan—It is fair to say, though, that in the current structure there are aspects of bill B—and I am sure that the officials will be able to show you those—that each state can customise.

Senator BOYCE—Yes.

Mr Sullivan—That is already there. All we were referring to is that I have been to at least one consultation, and I know that officers of the AMA have been at many others, where either representatives of the local state government or the ministers have expressed—let us say—a rather loose embrace of how that may play out for them in their state parliaments. If you do not have control of your parliament, then a degree of amendment that may happen to bill B that goes beyond the recognised areas that can be customised for it to be a national scheme. That is the point that we are making. Does the scheme become unworkable if one state or two states deliver an amended bill that does not apply universally across the country? That is our question. Are we now moving into an element of real politic that is difficult to manage?

Senator BOYCE—Given the history of the area, I hope that we can have new confidence in our ability to do this.

Senator WILLIAMS—Thank you for your submission. I note that you are very critical, but it is good to see you offer the solutions as well as your criticism. In principle, do you agree with an NRAS in one form or another?

Dr Pesce—In principle, we certainly agree with a national system for registration. We believe that the health system would be well served by doctors having the ability to practice in any state. Provided they were registrable in any jurisdiction, it would be a good thing if they were able to practice in any state in Australia. To that extent, having a national system would be able to deliver that. So we support the national system. Restating what I have already said, the main concern has been to address what we see as the potential for at least the perception of a conflict of interest. State ministers are under a lot of political pressure to deliver health services. On not

only one occasion, we have seen them take what we see as an easy road to it that does not necessarily in the long run maintain the quality and safety of services. The difference between the intention and what operates on the ground level is plain.

I will take this opportunity to raise the issues of poorly performing doctors—Dr Patel and Dr Reeves. If you understand what happened there, the normal registration process and the approval for them to practice was granted with appropriate restrictions on their practice. Because of the desperation to deliver services to an area where you are really struggling—and I understand this, because I work in an underfunded public hospital, too—allowed these people to morph into practitioners that had not been approved through the normal processes. The arm's length and independent process, which said, 'This is what you can do,' was not observed at an administrative level. They were allowed to practice beyond their approved scope of practice. The rest is history. That is a concrete example of what we see as a potential conflict of interest. I am not criticising the ministers for wanting to address that need to provide services in those areas. But there is always going to be a tension between that and an independent arm's length process that says, 'This is what you have to do to be a safely practicing doctor or health practitioner and you can't compromise that without risking the safety of the services that you are providing.' We understand why they want to provide those services, but there will be that tension. That will probably be an ongoing thing.

That summarises what our continuing focus on the independence of accreditation is for. It is not just an esoteric issue that we have as a mantra; it is because there is this very practical outcome in day-to-day clinical practice if you get it wrong.

Mr Sullivan—I will quickly add something to that. I will not read this out, but pages 3 and 4 of our last submission—the one that you have just received—goes to solutions and recommendations, which, for the record, are terribly important. There are four. They go to codification, transparency and accountability around the policy direction. That is page 3 and 4, starting about two-thirds of the way down on page 3. Suffice to say, as the president said, these were threshold issues for us. As it currently stands in the bill, it is not acceptable. We think that with changes along these lines—and I note that they are not drafted changes, but they at least point to areas where the amendments can happen—would improve the sense of certainty about how these powers would be exercised.

CHAIR—Have those issues been raised with the team?

Mr Sullivan—Have we given them through to—

CHAIR—The National Registration and Accreditation Implementation Project.

Mr Sullivan—They will be part of our submission. They submission is due in the next day or so.

CHAIR—By the end of this week, yes. It seems to me that those solutions are more clarification and definitional changes.

Mr Sullivan—Yes.

CHAIR—They are not things that are in the bill that need to be changed; they are things that are there that need to be explained.

Mr Sullivan—In some ways, we would see these as enhancements to the bill to better bring about some transparency, codification and accountability around the powers.

CHAIR—I have many questions, but we have not got time for them. You went through issues to do with mandatory reporting. Why particularly should medical practitioners who participate in quality assurance activities be excluded? We heard from the indemnity people this morning and they talked about spouses who are professional medical professionals, treating doctors and other professionals in advisory health services. I understand those. But why particularly should those in the quality assurance services be excluded?

Dr Pesce—Speaking at a hospital level, for example, there is no doubt that the provision of privilege for that information encourages reporting of near misses and failures in medical care. Once again, if it is thought that by reporting something you are going to get into trouble it does not encourage reporting.

CHAIR—So you will not fix your system.

Dr Pesce—You need to strike a balance. Especially within those institutions, there are other clinical governance systems in place to pick up on excess morbidity or mortality or poor outcomes. But what we really need to start off with is really good data. If you do not get data, nothing else follows. I understand why in the public interest sense this is a difficult issue, because there is always the worry that if there is not mandatory reporting of this then there can be cover-ups et cetera. I guess we need to acknowledge that perception of a conflict of interest in the same way that I mentioned it before. The profession needs to recognise its responsibilities, which are very heavy. But it is important that data can be collected without fear of disciplinary comeback so that we have a good database to work from.

Senator BOYCE—But would you accept, Dr Pesce, that there are going to be circumstances where clinical practice—not sexual misconduct or being drunk out of your brain or whatever—is such that it should immediately proceed to a formal complaints system?

Dr Pesce—That is correct, and the triggers for that are various—they can be from the patients themselves or from healthcare professionals who work in association with the individual involved. Certainly that is easier within the framework of, for example, an organisation like a hospital. I guess it becomes a bit more difficult in someone's private practice. But I guess the quality assurance thing does not apply so much there in the current system because there is no systematic quality assurance governing that area of practice.

In answer to your question, there are times when it would be quite proper to report incidents which have nothing to do with anything other than clinical competence, but an appropriate process has to be gone through of making sure that there is a clinical problem and you are not just responding to one bad case. You have to balance the facts—it is possible to focus just on one poor outcome and not realise that there are a lot of system issues involved in that poor outcome.

Senator BOYCE—I guess the question that the public might ask is: who should make that decision about whether or not it is a poor outcome and what should the circumstances of a poor outcome be—should it be made by a colleague or by an external assessment process?

Dr Pesce—You probably need a number of checks and balances in the system. You have your medical indemnity insurers, who will be getting reports of incidents. You have self-reporting by practitioners, who are required to report such incidents; otherwise, they could invalidate their indemnity cover. You could get it from lawsuits. You could get it from individual complainants. It probably needs to be recognised that there is a whole raft of potential triggers for an appropriate report being made, and that will, hopefully, cover the public interest needs.

CHAIR—In your follow-up submission, your supplementary submission, an issue that popped that was not in your original submission was advertising. I see the points that are in there and I take them as perfectly valid. Where did that come from?

Dr Pesce—I will take advice on that, but people have come up to me since my election and mentioned those issues, and I have reinforced them. They have probably been mentioned before but they may not have been emphasised in the way they have been on this occasion. There have always been issues that people have had concerned about, but on this issue people have come up to me and said, 'Look, we're really worried about this.'

CHAIR—And here is an opportunity, in setting up a new national process, for that issue to at least be considered.

Dr Pesce—Yes.

Mr Sullivan—And, Chair, I think it is basically a response to what we saw come out in the bill. These things have been discussed through the consultation process and, in fairness to the drafters, they have decided to respond, but we think the bar is too low.

CHAIR—You want to lift it up.

Mr Sullivan—What we have listed there are things that doctors abide by now, so, if we are going to have a bar, let's have it at at least that level.

CHAIR—In your supplementary submission under 'Advertising' it says:

iv. advertisements should not claim or imply that one practitioner is superior to another or denigrate other practitioners or services.

Does that operate across professions as well as internally?

Dr Pesce—We would hope that it would, yes.

CHAIR—Thank you very much. We know we are going to see you again later; that will be useful.

Dr Pesce—Thanks very much.

[2.09 pm]

MORAUTA, Dr Louise, Project Director, National Registration and Accreditation Implementation Project

CHAIR—Welcome, Dr Morauta. We have the letter which spells out your position and how the whole process is operating. We are all very much aware that you are not to be asked or expected to answer questions on policy, but it is good to remind us all in terms of process. I know that you are experienced enough that, if someone does ask you a policy question, you will not answer it. If you would like to, please make an opening statement, after which we will go to questions. I know someone from your area would have been listening to the evidence and would be aware of the submissions. I am not sure, but I think all of us have taken some notes on the submissions that have come before us, so we will go back and go over some of those if that is okay.

Dr Morauta—I do not have an opening statement, but I have for tabling another bit of the chronology—what has happened since I was here last time. As you know, at that time, ministers had not reached a decision in response to stakeholder concerns. They did that on 8 May. I think that was shortly after I was here.

CHAIR—It was, yes.

Dr Morauta—We went on and redrafted the bill in accordance with their directions, and then the ministers themselves approved the release of the bill. We are now doing consultations, very much as you are doing, but we have been going around the country. There is a list there of where we have been, how many people we have seen and so on. We have basically been consulting for three weeks of the five-week consultation period on the exposure draft.

CHAIR—Thank you very much. We note that the supplementary information you gave us after we last spoke with you was very, very valuable, and I know that the way you put chronologies and things together we found useful as a committee.

Senator HUMPHRIES—I have a whole series of little issues to raise. Possibly as I am raising certain things people will jump in and say, 'What's going on here?' We might start with the structure of the ministerial council role in respect of setting standards. Might I say at the outset, Dr Morauta, that all of the concerns that we encountered in the first round of this inquiry seemed to have been somewhat assuaged by the time we got back to the second round. Congratulations on having dealt with, apparently, a large number of those issues in the course of the consultations that you did before the most recent version of bill B. I think it is fair to describe most of the stakeholders as reasonably happy but with a few areas of remaining concern. We want to tease those concerns out today.

I think everybody we spoke to conceded that theoretically it is possible to have a situation where you might wish to compromise standards in order to deal with an area of need, which is the intention behind subclause 10(4) of the bill. But a number of people made suggestions on constraints to that power. One suggestion was that the power should be exercised only in

exceptional circumstances and that that descriptor of the rarity of its use should actually be inserted into the legislation. Other witnesses made the point that the legislation ought to require the ministerial council to set out reasons for its direction to the relevant board in which they reject a particular standard because it does not adequately deal with workforce issues. Has any consideration been given to those kinds of overlays on the 10(4) power and, if not, could I have your reaction to those concepts?

Dr Morauta—If I could just go to process, what is going on at the moment is that we are getting all these comments in from people—and you are right that how 10(4) is constructed is an area of interest to people. The next step is that ministers will consider this and decide what they want to do about it. It is clear that it is an area of interest and, as we did before and as you could see, as a result, in the bill, all the areas of interest raised by stakeholders at that level—these are high-level issues—will go forward to ministers for their consideration. Which way they will go on that I do not know, but they will certainly receive advice on that.

Senator HUMPHRIES—I understand that. Those issues are to be considered by the ministers. We hope that what we recommend in this committee will also be considered by the ministers and that they will take on board what we have to suggest in good faith. If you were observing this process and you saw those recommendations being made to the ministers, what sort of advice would you give as to whether they were sensible recommendations or not? Is it sensible, for example, for there to be a public description, a statement, by the ministers of their reasons for using the exemption power in section 10(4)?

Dr Morauta—I really think that is a matter for the ministers to decide, Senator Humphries. I can put forward what people are saying. You are right: they are going into the area of how this 10(4) works. The AMA have a slightly different set of changes that they want to make to it. There is a lot of discussion, but what the ministers will decide is appropriate for them to decide and for me not to comment.

Senator HUMPHRIES—I will take another tack. Are you aware of any circumstances in which ministers meet in a body like the health workforce council where they exercise powers under statute and are required to provide statements of reasons for the exercise of those powers?

Dr Morauta—Off the top of my head, no. I do not know how many times they act. I know that, under the national blood legislation, they act as a council under legislative powers, but I am not sure in how many circumstances they have this kind of legislated regulatory role. If I could go to something you raised, Senator. In your earlier questioning about whether ministers on their own motion, if you like, could get into accreditation standards, the AMA tabled a piece of paper regarding their understanding of it, which was that there was no own motion power. That is also my understanding of what the legislation says, and I can confirm it. It is not that ministers could have an idea that they want to do something in relation to an accreditation standard and sail in and do it.

The legislation is very lopsided in that respect. Under the draft that we have before us, it allows them only to give the national board a direction when there is a proposed amendment or new standard being circulated on the motion of the board and the accreditation agency. This is quite a constraining provision. If I could explain it like this: there is a tension between the professions not wanting to see ministers degrade standards and the ministers not wanting to see

professions raise them so that there is a massive amount of expense where it is not justified—some kind of tension like that. This is a lopsided provision. It is that ministers are not able on their own motion to come in and do something, but the profession can come forward and put a proposal for enhanced standards. That is really a very protecting arrangement as it is drafted, and I would confirm to the committee that the AMA's tabled paper on what it all means is, in our view, correct.

Senator HUMPHRIES—So it is a bit like the Senate's power to disallow government regulations. It cannot change the regulation; it can only reject it.

Dr Morauta—That is it, yes. It rules out the kind of situation where they come in and say: 'Oh, we've got a crisis. We're all going to have X happen in a particular situation in relation to an accreditation standard.'

Senator HUMPHRIES—Would you envisage that the structure of the bill will allow that to be a reasonably public process? Is there any provision in the bill that prevents a board from disclosing standards which it refers to the ministerial council?

Dr Morauta—No. At the moment, if they give a direction, that has to be published so that they are accountable. It has to be published in a certain way. Also, if by chance the board were to reject a direction or if the board refused an accreditation standard as proposed then the accrediting authority, the Australian Medical Council or Dental Council or whoever it is, has the right to publish their advice. There is also a consultation provision. When somebody is developing an accreditation standard there has to be a consultation process, and that is also required in the legislation. So, at the point where things were being thought through, we would expect a public consultation process, things being very much on the open record, and everybody would get their say and probably their say would also be open. There is a requirement for extensive consultation on the development of an accreditation standard.

Senator HUMPHRIES—If the board feels that standards are being threatened by the ministerial council, they are perfectly at liberty to ventilate that in the public arena by virtue of the way in which they can disclose, or these things can be put into the public arena without too much difficulty?

Dr Morauta—I am not sure what the boards would do about it, but the ministerial council certainly has to place its policy directions on the public record.

Senator HUMPHRIES—Further to the issue of the national bodies and their relationship with the boards, we had a few representations about the structure of the boards and about their need to cover representation by smaller states. You may be aware that some witnesses have suggested that there are particular issues within individual states, particularly the smaller states, in remote places like the Northern Territory which need to be in the minds of the members of national boards. In those circumstances, it would be inappropriate to potentially exclude some of those smaller states from being individually represented on national boards. Obviously, bill B goes the other way: it has a standard size for every board, doesn't it?

Dr Morauta—No. It is not a standard size in bill B, but there is a requirement that the larger jurisdictions all have a seat—the practitioner member, not the community members—and that

the smaller jurisdictions have at least one. That is the board. The size and composition of the board are determined from time to time by the ministerial council both under the existing act and under bill B. If ministers said that the board was going to be, say, 12, then it would be perfectly possible for the three smaller jurisdictions each to have a practitioner member on a particular occasion if ministers wished to do it that way.

Senator HUMPHRIES—But, alternatively, they might miss out, mightn't they?

Dr Morauta—Yes. The draft allows them to miss out.

Senator HUMPHRIES—Can I get an idea of why, at the end of the day, it was felt that that was a better structure than going for individual representation by smaller states?

Dr Morauta—Actually, if you go back in the history, there was no suggestion of representation in the earlier cuts of this legislation or in the first act. It was only as discussions between the ministers progressed that this proposal to have the five larger jurisdictions specifically represented on the board came up. So I think it is very much in the realm of ministers dealing with each other around the issues in the scheme that this proposal came up.

Senator HUMPHRIES—Is it possible under the legislation for a person to serve on both a state or a territory board and a national board?

Dr Morauta—Yes.

Senator HUMPHRIES—You could not say whether it was envisaged that that would be a convenient and likely arrangement in some cases in order to improve connection or dialogue between the two levels of the board?

Dr Morauta—I think a couple of things. I think that ministers have made it clear that they are very interested in continuity at the state and territory levels. So they have introduced this concept that, if you are on a state board on 30 June, you are still on it on 1 July. You are still holding the same baby, if you like, after the transition. I think ministers have expressed an interest in receiving nominations from current boards for the new national boards.

Senator HUMPHRIES—That is good.

CHAIR—Dr Morauta, is it possible to have different sized boards for different professions?

Dr Morauta—Yes.

CHAIR—So there could be some variation. We have had the dentists come forward on how they think their dental board should be Their particular claim is that, because they have other professions linked into the overall dental industry, they need to have special treatment. Psychologists are already working in a national framework. They raised issues about the fact that their national board is not based on a state jurisdiction and that the best people to represent psychologists at a board level could all well be from the one state. There was a bit of uncertainty as to whether they were going to have a predetermined board and make-up or whether there was some room to move. Is there still room to move in bill B?

Dr Morauta—We are out on an exposure draft for everything in bill B and people can comment on it. But bill B itself does not stipulate the size of a board.

CHAIR—I did not think it did either.

Dr Morauta—That is right. It was always thought that from time to time ministers would want to call the size and composition of boards, because things change. I do not think anybody is trying to nail the size of the board in the legislation but the parameters—what has to happen—is different from the first bill. But this jurisdictional representation thing in the second bill is very much what the ministers want to see there.

Senator BOYCE—I am trying, Dr Morauta, to recall the note that I took on evidence from the Psychological Society on the topic of conditional accreditation. That was an issue that they raised, and I am hoping that you remember the context.

Dr Morauta—I know what it is, because it has come up from several stakeholders. What has been said to us is that in the legislation we only allow for a university program to be accredited or not and in fact they have a very widespread practice in these accrediting authorities of giving partial accreditation or conditional accreditation. For example, they might give accreditation for the first year and see how it works out. So we had a meeting with the accrediting authorities, and they suggested that there was a need for a change there to allow for conditional accreditation of programs.

Senator BOYCE—So that is on your—

Dr Morauta—That is on my list of things, yes.

Senator CAROL BROWN—I have a question on the board's composition. If indeed the national boards can be larger than what is stipulated in the draft bill, where is that decision made? Is that at the ministerial council?

Dr Morauta—Yes. What it says, both in this bill and the one under which the current appointments are being made, which is the first act, is that the composition and mix of the board is as determined from time to time by the ministerial council. That has always been regarded as important, because if you had a new sub profession come up you might want to have a different sized board or a differently composed board. What this bill and the first act do is say that there are some rules around this. We have to have no more than two-thirds of practitioners—no less than half and no more than two-thirds. The chair must be a practitioner member. In this draft of the bill, the five large jurisdictions are guaranteed a member and the three smaller ones have to share. That is the minimum requirement. What happens is that ministers can certainly play with the size of the board on any occasion that they want. Or they might want various bits represented on it—dental is a good example, because it has prosthetists, hygienists and therapists in it. How many of those do you want on the board? Ministers can at any time decide what they want there. That is the flexibility in the current act, which enables them to decide. That is also in this draft bill.

A lot of the comments that we are getting are about the current round of appointments and the decision of ministers to run with nine-person boards. Those are decisions that have been taken

under the first act, because that is what the appointments are being made under. They bear on what bill B says, but people are seeking in some cases a change to what ministers decided on mix and composition under the first act for this current round of appointments.

Senator CAROL BROWN—We heard evidence earlier today about the fact that the community representation on the boards will have a broad community focus. The Public Interest Advocacy Centre wanted to see a consumer focus on the board.

Dr Morauta—The current legislation and the draft of bill B both say that there have to be community representatives on the board who are not practitioners and who have never been practitioners. These representatives must make up a minimum of one-third of the board. When we did the very first consultation, people told us that there were a lot of token community members around. One person or even two get a bit squashed. The idea was that there had to be a real presence on the national board, and that is where this 'no less than one third' comes in.

Senator CAROL BROWN—I suppose their concern was really that they saw that with the community representation—the two that are stipulated in the draft bill—the person had a broader community focus rather than just a consumer focus.

Dr Morauta—I think they are not described as consumer representatives in the legislation; they are described as community representatives, and that is very much—

Senator CAROL BROWN—And that was their point.

Dr Morauta—That was the concept, yes.

Senator HUMPHRIES—To clarify, all the ministers appoint all of the positions on the boards rather than, say, the Western Australian minister appointing the Western Australian representative on the chiropractors board.

Dr Morauta—It is a decision of ministerial council as a whole. They will obviously be the people who know the people in their state who may make a contribution.

Senator HUMPHRIES—Turning to mandatory reporting, we have been told that this was not in the earlier versions of the legislation and has now appeared rather suddenly at the final iteration of bill B. It is a fairly significant change for at least some areas. I think we were told that with respect to doctors there has been no mandatory reporting, except in New South Wales, so for most of the profession in Australia this is quite a significant change. I am a little bemused as to why mandatory reporting did not appear to be an issue in the early stages and has suddenly become an issue now. Can you describe to me the sorts of stakeholders who pushed stuff onto the agenda between the most recent round and the last round.

Dr Morauta—I will just go back; mandatory reporting was very definitely raised in the consultation papers that we issued last year, and we did get extensive feedback on it in the discussion. We had a whole complaints forum in New South Wales that spent quite a lot of its time on mandatory reporting. Nearly everybody had views on mandatory reporting in that first round of consultation. So we have had it on the table right from the beginning. It was on the table because it is clearly something that is present in some jurisdictions and in some professions

now and ministers have had these provisions through their houses already and they knew that their houses were very interested in this and thought that it was an important adjunct. So I do not think it is new. By and large we got quite a strong response in the first round in support of mandatory reporting but, as always, what are the details and how does it actually pan out. We did get a largely positive response on mandatory reporting's inclusion in the legislation.

Senator HUMPHRIES—That is a little bit surprising in that—admittedly we have not heard every professional group give evidence in the last two days—all of those who have given evidence have expressed concern about mandatory reporting. Would you say that organisations representing particular areas of specialty or the medical workforce are generally in favour or opposed to it. Can you summarise the position of professional groups with respect to mandatory reporting.

Dr Morauta—I am not positive now as you are saying it because we do not have all of the submissions in. What I have observed in the discussions in the forums is that people are wanting the detail to be right. If we are going to have mandatory reporting we want it to look like this or we want to have protection for that person or the other person. It is more about the detail but wait till we get the submissions in and see whether people are doubting it, in the way you are describing, as an overall concept.

Senator HUMPHRIES—We may only have a relatively small slice of opinion on this but it appeared to be uniformly concerned and—hostile might be slightly too strong a word—reserved about the issue of mandatory reporting. Desire was expressed for more flexibility about whether people should be brought into a system of mandatory reporting or not. I flag that for your interest. You will no doubt have your own area of feedback with respect to that. I will just follow-up by saying that we have heard from a couple of groups about a code of practice developed by the AMC for doctors. The suggestion was made that a similar code could be developed for all health professionals that might constitute a way of enforcing a culture of appropriate reporting without going to the extent of mandatory reporting. Was an option like that—an extensive code—considered as an alternative as you were developing the mandatory reporting proposal?

Dr Morauta—Yes, because also nurses have a similar standard. There are quite a few professions where they have tackled this issue in that way. So it was always one of the options not to have a legal requirement for mandatory reporting. But there are legal requirements in some jurisdictions in some professions now. A question for ministers in designing a scheme like this is often, for example: for the minister to have these arrangements are these things that they could put through their parliament and say 'let's take mandatory reporting out in New South Wales'. Is that a reasonable proposition? Those are the sorts of things that might bear on minister's consideration of the matter.

Senator HUMPHRIES—Would it be fair to say however that most health professionals in Australia today are not yet subject to legally enforceable mandatory reporting requirements?

Dr Morauta—Yes, I think that is right.

CHAIR—On the issue of mandatory reporting there were concerns raised by witnesses, particularly by the doctors. I am not saying that every witness had negative views about it, but

particularly the doctors and their medical indemnity people did have concerns. They did have a fallback position on people that they would suggest be excluded from it. That seems to be one kind of option—that if mandatory reporting is the desired option of the ministerial council, particularly in view of the New South Wales experience where they already have it, then at least there would be some groups that would be excluded. I think that would be a fair assessment of the evidence. They are all going to give that evidence to you anyway.

Dr Morauta—It would be interesting to see where consumer groups and community groups come out on these exemptions. Also I was just trying to reflect how many exemptions there were in the New South Wales arrangements. I am not sure.

CHAIR—I cannot remember.

Dr Morauta—Clearly there is a tension here—and I think Senator Boyce identified that—between the public and the professions. It is one of those areas of this legislation where there is almost a natural tension. We will just have to see where ministers want to take that.

CHAIR—Senator Boyce has just suggested that we move on to issue of the public interest assessor position. That has been a common area of interest.

Senator BOYCE—Yes, I was thinking that it seemed to follow on from the mandatory reporting area. We have had evidence—and you would have heard some of this evidence, Dr Morauta; it characterised the evidence we have had over the last two days—that people really have not had the time, the ability or the information to assess what the public interest assessor is going to do and whether this is an extra and unnecessary complication or not. Perhaps you could explain what the role of the public interest assessor is going to be.

Dr Morauta—The role of the public interest assessor is most clearly seen in the ACT healthcare complaints legislation now—where the healthcare complaints commissioner in the ACT performs exactly that function. The function happens at two points. At the point of preliminary assessment of all complaints and notifications, the public interest assessor, if you like, sits alongside the board. The board reaches a view as to what should happen to this and the public interest assessor has a look at it to see whether they agree with the board or not on the treatment of that matter. They do not decide what happens to it but they do decide whether they are within the scope. For example, 65 per cent of complaints at preliminary assessment are discarded—they are found not to be within the scope.

Senator BOYCE—So this is only in relation to complaints?

Dr Morauta—It is only in relation to the complaints area and it is only within this legislative framework. So when the board first look at a complaint—the first time the complaint is there—they have to decide what to do with it. At that stage about 65 per cent of the complaints are currently dismissed or are found not to be within the scope. At that stage the public interest assessor would come in, look at what the board had done and have the option of saying, 'I think we need to have another look at this one. We need to do some more work on this one. This looks to be in a slightly different position to the others.'

Similarly if the PIA says, 'I think that we should not take that one further,' but the board thinks that it should go further then the board takes it further. So it is a presumption that whoever thinks it needs a bit more looking at wins the argument. But then the board handles it; it is not given to somebody else to handle.

In the second stage after an investigation, and we are getting down now to a much smaller number of these complaints, there is a very important decision taken by the board as to what happens. It can either go to a tribunal, which sets it up for deregistration and everything, or it can be handled as a conduct matter by the board. Those are the sort of basic choices there are there. Once again the public interest assessor, just as the healthcare complaints commissioner does in the ACT, would come in and look at it with the board. If they wanted it treated more seriously—for example, by sending it to a tribunal—when the board did not then that would view would prevail.

So it is an extra check reflecting what we got—which was a very divided set of messages across the country in relation to complaints handling. The community groups got together across the country, as you will see in their submissions, and came up with the view that they wanted more independent assessment like we had in New South Wales.

Senator BOYCE—So it was a 'like' position.

Dr Morauta—They did not specify what it was except to say that they liked the New South Wales system more than almost everybody else did. Ministers were apprised of the fact that there was this quite strong view that somehow the boards could not be trusted and you needed another player in the game—not that this would be something the boards would necessarily think was true. So they put this public interest assessor in. On the question of costs—

Senator BOYCE—That was my next question.

Dr Morauta—which is an issue that has been raised, it really depends on which way the individual jurisdictions go. So in the ACT you would expect them to say, 'Our PIA under this law is the HCC because it is exactly the same thing.' Some jurisdictions are looking at giving this role to their healthcare complaints commissioner, in which case it will be funded by government. It may not be a great deal of extra work in some jurisdictions; and in other jurisdictions it might be quite a lot of extra work for the healthcare complaints commissioner.

So there is flexibility in the legislation for the role to be performed in different places, and some of those might be more efficiently done with the healthcare complaints commissioner, but it is up to the jurisdiction to decide that. Until the jurisdictions have decided, it is a bit difficult to see how much would actually come back to the registrants in terms of cost. We cannot anticipate that at this stage.

Senator BOYCE—And what about the independence and the appointment of public interest assessors?

Dr Morauta—That is a statutory office holder at the national level. It has been pointed out that we do not have delegations in the legislation, and obviously we need delegations for that person. Insofar as people are using the default arrangement within the scheme, that public

interest assessor needs to be able to delegate to somebody who is appointed in the jurisdiction in the state office so that they are next to the boards who are doing the complaints and so that nothing has to go to Melbourne or something like that to be fixed.

CHAIR—There was a lot of concern about the cost. That came out from just about everybody. Everybody who came to give evidence was concerned about the cost—they were unsure about it. In fact the pharmacists actually put on record that they are unhappy generally on the basis that any proposal in the legislation is uncosted. Their view was that there should be a full costing released as well as a regulatory impact study. They felt that would be an appropriate mechanism to give strength to any change. That came out in evidence yesterday. So the fact that the new position was seen as new and having an impost in terms of cost was important.

Senator BOYCE—I note also that the Australian Dental Association said that the public interest assessor might have a role if it was just for little jurisdictions—the smaller states.

Senator HUMPHRIES—I would like to jump back quickly to the issue of the boards. I meant to ask as well about concerns expressed by some of the stakeholders about the financial arrangements supporting the boards. The agency—whatever it is called; it may be APRA—enters into service arrangements with the boards and provides for their needs. But as I understand it the boards themselves do not directly administer the fees that come in, which people pay to register in a particular operation group. So they deal with the policy issues but they do not directly administer the fees.

Dr Morauta—This was a matter of concern in the consultations, and you will see that the bill has moved on a bit from there. Every board now has its own account and there is a guarantee that they are not subsidising other boards. So it is not a case of 'I am paying for the chiropractors and the chiropractors are paying for somebody else'. There is also a very explicit statement on expenditure which says that it is either in accordance with their budget or at the direction of the board. So there is a response in the bill to the control of funding, which I think is much clearer than the previous arrangements were, that not only do they reach this agreement but also they actually control their money more directly.

Senator HUMPHRIES—Who sets the fees? Does the board set the fees?

Dr Morauta—Yes. They have to do it within the context of a health profession agreement with the agency, but that is just to make sure that all the corporate costs are distributed in a reasonable manner. If the boards are not happy with the fees or with the fees that are emerging from their budget, they can decide to disagree with the agency and take the matter to the ministerial council.

Senator HUMPHRIES—All right.

Senator FURNER—I think the last time you appeared, Dr Morauta, Senator Bilyk—from my recollection—raised the issue of the disparity in registration fees between the various states as a particular concern in Tasmania. If a board sets the fees or determines a set fee and a group is dissatisfied with the amount, where does it go from there?

Dr Morauta—The legislation provides for a single national fee across all jurisdictions in a profession. I think there are two levels of possible anxiety. One is that the Tasmanians might not like the national fee because it is a big jump from where they are now, or something like that. In fact, that would not be the case. The lowest fees are in NT and New South Wales on average. I think I tabled or sent round a thing with all the fees in it.

Another issue is whether the national board can live with the fee. If a board does all its arithmetic and looks at its numbers and says, 'Do we like this fee?' or 'Do we think that's too much?' it might then say, 'We'll go to our reserves and we'll spread it over two years.' There are a number of different things they can do. I think it would be for a subgroup of the profession to go to the national board with their problem, if they did not like the effect of the fee. One proposal that has been put up is that, if the fee was too sharp for registrants, the national boards could move to a single fee over two years. The national board itself has a number of ways of ameliorating what it thinks it has as a result. It will get reserves handed over to it from the other boards and it would have the chance to dip into its reserves if it felt it was getting a jump or a bump, or it could spread it over two years and so on. There are some things which are quite naturally large savings for boards, and that is in the provision for exceptional cases. Because they are now in a national pool, they have a much bigger pool to play with. Sometimes these exceptional cases were very burdensome on the small jurisdiction that was handling them. That is how that works.

CHAIR—Is there any intent to have state involvement in funding?

Dr Morauta—No. I think the government were quite clear in the IGA that they wanted this thing to pay for itself.

CHAIR—I want to put that on record because it was raised in a number of submissions.

Dr Morauta—However, there is one exception to that. The New South Wales government has indicated that it is not trying to pass the costs of the Health Care Complaints Commissioner in New South Wales to the rest of the registrants, and they have stated that publicly.

Senator HUMPHRIES—Can I turn to some of the special pleading that the committee got about different situations. The podiatric surgeons were up in arms because they had been separately registered in the first two versions of the bill and then they were suddenly cut off in the third and final version, bill B. Why has that happened?

CHAIR—This committee has had a long history with the podiatric surgeons. They have come before us on a number of times about their concerns.

Dr Morauta—There was a big debate in the run-up to this bill about how specialist registration should be handled. The solution that has been put in the bill is like this: medicine and dentistry are going to have specialist registration from 1 July 2010 under the powers in this bill. But they still have to come back to the ministers with the list of specialties that they want to have as the registration base for specialist registration. Any other profession can bring forward a proposal on specialist registration; there is a process for that. In some cases, they would be able to do that during this year. But if for some reason in one particular state or territory they were not able to do it during this year and they had specialist registration prior to 1 July—WA has lot of

specialist registration now compared to other jurisdictions—they are allowed to retain specialist titles in their operation for three years until such time as the consideration of specialist registration in that profession has run its course.

Senator HUMPHRIES—Nonetheless, in the earlier versions there was already registration built in for podiatric surgeons. It has now gone. Why did it go in that third version?

Dr Morauta—I am afraid that I am not up on this. I will just see whether I have any information. I was not aware that they were provided it in previous versions. I will take that one on notice. I am not sure whether we have the answer to that. We are thinking that they were not in the previous versions as a form of specialist registration, but if we go back and check and we find to the contrary, we will provide advice to the committee.

Senator HUMPHRIES—That would be good. There were various suspects named by the podiatric surgeons but we will not repeat those here. Conversely, we are told that in the earlier versions of the bill there was no inclusion of separate registration for, I think, orthoptists but it has suddenly appeared in the last version. I think I have got that right. Do you have any explanation as to why that occurred?

Dr Morauta—The orthoptists are not getting registered. There is a reference to the orthoptists in clause 136, and that is to do with a practice restriction relating to optometry. So we are not registering orthoptists, and we never were. But there is a reference to them in this legislation to which some people have said is not appropriate because they are not registered. So it is a slightly different point. There is a lot of discussion from the optometry profession on the way in which this particular practice restriction—there are very few practice restrictions in the legislation—is worked, and they are continuing to provide us with advice on that.

CHAIR—That discussion is continuing?

Dr Morauta—They are still providing us with suggestions about this thing. We are not registering them. It is just that they have got into the legislation and there is a view by some parties that they should not be in there.

Senator HUMPHRIES—We will watch the outcome of that with interest. We were told by the surgeons that they were concerned about clause 134 in that there is an idea of limited registration.

Dr Morauta—I know what this one is.

Senator HUMPHRIES—It should not mean that, when they specialise, they lose the right to their general area of practice by virtue of having an existing limited registration. Can you comment on that concern?

Dr Morauta—This one has attracted quite a lot of interest, particularly from the medical profession where specialist registration is a major part of their business and also where they have quite a lot of limited registration area of need practitioners. The discussion is about whether people in an area of need should be able to call themselves a specialist. This legislation in the clause you discussed, 134(3), says that they do not breach the title protection should they use the

title. There is further work on that to see how what was intended by that section could best be put in place. We have had some discussions with the medical colleges in the last week about that.

Senator HUMPHRIES—But I assume it is not the intention that, because a person obtains an additional or specialist qualification, they in any way lose their right to their base area of qualification.

Dr Morauta—No, I think the concern here is that people may have a quite narrow form of specialist qualification which enables them to do some tasks but not the full range of tasks of, say, a surgeon or something like that, and what are they allowed to call themselves? At the moment, it is actually quite muddled out there. They are called all kinds of things, including specialists. But, when you have created a specialist register, you have created something whereby in the public domain you need to be able to distinguish between specialists who have the full qualifications for a specialist and specialists who have narrower qualifications. There is still quite a lot of discussion going on about how to handle that. I had a meeting which involved RACS and some other parties last week on this one.

CHAIR—Have you any more questions in that area, Gary?

Senator HUMPHRIES—No. That is all on special pleading that I was going to refer to.

Senator BOYCE—Just following through on who can call themselves what, there were some comments by the psychologists on the issue of people offering psychological services. The other one that I noticed with interest in the AMA's submission, which I do not recall having been there before, was the idea that people who are doctors but not medical doctors should have to specify that they are not medical doctors if they are offering health services. Have these concerns been raised with you?

Dr Morauta—The doctor one has been around for a long time. That had led to submissions from people with PhDs at universities in great alarm at one stage.

Senator BOYCE—I would imagine that it still would, Dr Morauta.

Dr Morauta—That debate has been running along about the title of 'doctor'.

CHAIR—Several centuries.

Dr Morauta—On psychology, they are in a rather different position. They are a profession that has a health segment and a non-health segment. But they are all in the scheme. We believe that the arrangements in here enable each board to make a sensible resolution of these matters—for example, with endorsements or through some other method. How the national board on psychology works that through I am not quite sure at this stage.

Senator BOYCE—What is the part of the legislation that would enable this? Do boards simply have that ability or would the bill specifically give them that?

Dr Morauta—The bill, because it is kind of an overarching framework, would not say, 'The psychologists can do this.'

Senator BOYCE—No, but—

Dr Morauta—What you have is that in the endorsement section you have endorsement for an area of practice. That might be a place where a board might go to pick out a particular area. They could then go to ministers and say, 'We think we should have an endorsement in this area of practice.' That would be one way that you could distinguish between different types of training in a profession. The legislation goes very much back to training. Is there a training program? It is not about title per se; it is about having the qualifications to do something different than other people. It might well be that the endorsement by area of practice is a place that people go for describing that.

Senator BOYCE—But the concern of the psychologists was also that non-psychologists who might offer a mental health/counselling service were using the phrase 'psychological services'.

Dr Morauta—It may be that there is a case for changes in what is protected. There is an almost endless supply of things that they can do. But it has been—

Senator BOYCE—I realise that.

Dr Morauta—People are coming in with suggestions on what should be protected. Just as a comment, I think that the more titles you protect, the more inventive the other people become. We have people who do dry needling now because they are not acupuncturists, and so on. This whole protection of title thing is quite a tricky area to get the right things in the bill. But we will certainly look at whatever they put forward.

Senator BOYCE—So that finishes the 'who calls each other what' area.

CHAIR—The other professional issue is chiropractors and cervical manipulation. That was the other particular—

Dr Morauta—That is another practice restriction issue. The chiropractors and the osteopaths are concerned that this is limited to the cervical spine and is not the full spine.

CHAIR—That is right. So you are aware of that one.

Dr Morauta—Yes.

Senator BOYCE—How did that decision to just include cervical spinal manipulation in the legislation—

Dr Morauta—There were two things. One was a regulatory question: which jurisdictions are regulating this now? There is no restriction on spinal manipulation at all in Victoria. They deregulated. That is quite an important message. The Victorians maintain that they have had no increase in things going wrong since they deregulated it. So when you get into the space of, 'Should we regulate something or not?'—

Senator BOYCE—I did furiously try to seek some data in this area, and there does not seem to be much.

Dr Morauta—This area is very data deficient, but there was a look at the data. I wanted to point to the fact that one jurisdiction had deregulated this area and in the discussions maintained that they had suffered no adverse consequences in that jurisdiction. That makes it quite a contentious area between governments.

Senator HUMPHRIES—The dentists suggested that what they saw with the new structure seemed to have a tendency to create more red tape than existed before because of the national boards being superimposed on the local ones. I suppose the idea of this whole structure is that we actually end up with more streamlined processes and consistency across the country and, therefore, presumably there will be theoretically less red tape and an overall lower cost structure because it is standardised across the nation. Without being categorical can you say that that is the direction in which this scheme is heading?

Dr Morauta—It certainly was right in the beginning with the Productivity Commission and so on, as you are talking about. The concept they used is lower cost to the economy. I do not think there is much doubt in any of these things—this is part of the COAG streamlining regulation agenda—that you are reducing costs to the economy, particularly for people moving around, such as the deterrent cost if you go to work in the Northern Territory and you have to get reregistered. About 60 per cent of the registrants in the Northern Territory are registered somewhere else as well. The thing is a nightmare out there. That kind of level of economic analysis is what you are talking about in this thing. At the microlevel it might look to one registrant as if there were more they have to do; we do not yet know. Also, the registrants certainly do not know how the IT system will help them and how the efficiencies of that will play out over time. We will have to have a look at that. But the economic argument is that removing regulatory barriers within the national economy has to improve the mobility and flexibility of a labour force that, as we well know, is under pressure in this area.

Senator CAROL BROWN—Could I ask what the rest of the time line is for this at the NRAS? When will it be going to the Queensland parliament?

CHAIR—Could I just widen that; it was going to be in the question I was going to use to wrap it up. There are two things: one is the overall consultation and the process of consultation. I know it seems to have been going on forever but concerns were still raised by various groups and in particular by the public advocacy person about the lack of consultation with—I do not know if you used the term ‘real people’. But the inference is that community members who will be impacted on by this legislation have not been engaged in the process. Also, there is the concern that the short five-week period from when bill B became public to when the consultation period finishes is not enough time, that it has been rushed and that people will not have time to have their views considered effectively. The next point is that after the period people will not see the bill again before it goes to the Queensland parliament, at which point they are locked in.

Senator CAROL BROWN—That is exactly what I was going to ask.

CHAIR—They were the kinds of issues and then, from what Senator Carol Brown said, exactly what happens next. A couple of easy questions there!

Dr Morauta—What happens next is that we take all the advice we have received and any other advice, not just in the submissions and in the forums but from wherever, and we give ministers a sort of a menu of issues that we need to sort through. Meanwhile there is quite a lot of what I would call drafting issues, where people have said, 'If you wrote it this way it would be a lot more sensible, or we could see what you are doing,' and there will be a lot of that work going on across government.

CHAIR—One group pointed out that they had found 125 drafting errors and we encouraged them to be in contact with your group. I just cannot remember which one it was; it was yesterday.

Senator BOYCE—It was yesterday and I think it was 120.

Dr Morauta—I am sure that it would be most useful if they were. We have had a lot of drafting type comments and they are very helpful. Some of them go to the style of drafting too. There are some aspects of the style of drafting that are difficult for people to read and those need to be fixed up. In terms of general processes, we are looking for ministers to be able to sign off on the bill before it goes into Queensland parliament so that it can get into the Queensland parliament around October. But this is all subject to ministerial processes and their consideration. The questions of what people get to see before that goes in there is certainly something that we will be raising with ministers because other people have said to us that they would like to see the bill again or they would like to see ministers say what the summary of the main things they have asked to be changed is. Those issues will be raised with ministers for their consideration.

CHAIR—And the time frame is still hopefully around October, but subject to—

Dr Morauta—Subject to ministers reaching decisions on these things.

CHAIR—On the point about people who are interested and looking at the bill before it goes to parliament, is there any intent to have the proposed bill then circulated again before it actually goes into the Queensland parliament?

Dr Morauta—No, ministers have not expressed such an intention at this stage. But obviously, as they always do, they will consider what people are saying.

CHAIR—Thank you for your evidence. If we have further question we will put them on notice for you. All the witnesses who came to see us these last couple of days are all submitting to your process and they will raise their issues there as well.

Committee adjourned at 3.05 pm