Dear Mr Snowball

This joint submission is made by the Australian Medical Association (the AMA), the Obesity Surgery Society of Australia & New Zealand, the Australia and New Zealand Rhinologic Society; Australian Orthopaedic Association Limited; Human Genetics Society of Australasia; the Australian Medical Acupuncture College; the Australian Paediatric Society; the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists; and the Australian Society of Ophthalmologists.

The AMA and the medical profession is committed to offering the highest standards of care to patients. However, the complexity of the delivery of medical care and the sheer volume of services provided every day means that dissatisfaction with some incidents of care, and instances of harm to patients, are inevitable.

The health sector has taken a multi-pronged approach to minimising and dealing with dissatisfaction and harm.

The process of managing the concerns and complaints of patients is critical to the functioning of the health system. The appropriate, expeditious and fair management of complaints gives patients confidence and reduces the sense of harm or dissatisfaction from patients who experience real or perceived adverse outcomes.

Accreditation arrangements require health care providers to have processes to accept and manage healthcare complaints and feedback and to make improvements to systems of care.

The health sector has done an enormous amount of work on open disclosure to foster a culture within health service organisations and by clinicians to communicate openly with patients when health care does not go to plan.

Both the complaints and open disclosure processes seek to provide patients with a rapid response and remedy. Legal avenues of redress are available to patients, underpinned by a sound medical indemnity industry.
The medical profession has led the way in finding models to ensure the management of practice is addressed in a broader fashion to continually improve patient safety and the quality of care. The Audits of Surgical Mortality are a joint undertaking between the Royal Australasian College of Surgeons and State Health Departments to ensure that all deaths during surgery are clinically reviewed. This activity informs measures to improve quality care and competent practice.

The former state based arrangements for medical practitioner registration and regulation were developed and refined over a long period of time.

Under the National Registration and Accreditation Scheme for Health Professions (the scheme), the regulation of medical practitioners by the Medical Board of Australia (MBA) is the final point in a long line of mechanisms to ensure quality and competent practice and to protect the public from harm in healthcare. It is the MBA’s role to set the standard for competent and ethical medical practice and to restrict practice as appropriate when a practitioner departs from accepted standards. In essence, it is a disciplinary process because the MBA can determine the practitioner’s registration status, and therefore their livelihood.

It is unfortunate that the scheme is often judged to be ineffective, either because the number of practitioner “prosecutions” is too low, or that the number is not zero. In both cases the supposition is that the scheme and/or the MBA has failed to protect the public from harm and/or punish the practitioner.

In that context, history has shown that Health Ministers react quickly to make wholesale changes to medical practitioner regulation, often on the basis of isolated cases, and without a proper understanding of where any ineffectiveness and inefficiencies truly lie. This has proven to be a mediocre (and expensive for the medical profession) approach to problem solving.

No scheme that is used to regulate health practitioners will ever be judged to be perfectly effective.

It is disappointing, therefore, that the review has not sought to analyse the effectiveness of the scheme using the case information that has accumulated after 4 years of operation. A proper review of the effectiveness of the scheme would have included some comparison with the outcomes of the former state based arrangements.

Consequently, there is no analysis, let alone evidence, to support the options offered in the consultation paper.

This information might have assisted the AMA and other stakeholders to objectively critique the options and to respond to the questions in the consultation paper. It might also have helped those “outside” the scheme to become better informed about the effectiveness of the scheme.

Therefore, the AMA is unable to categorically respond to the questions and options in the consultation paper. We are not comfortable that any changes should be made to the scheme until there is adequate identification and quantification of the problems, and a full analysis of the impact of the proposed solutions.

When that occurs, the AMA stands ready to work with the MBA and the Australian Health Practitioner Regulation Agency (AHPRA) to identify where the scheme can be improved so
that departures from accepted medical practice can be dealt with quickly, fairly and efficiently.

On that basis, we provide what we consider to be a reasonable opinion on the proposals made in the consultation paper.

**Accountability**

In your reflections in Part 1 of the Consultation Paper you state that there is “neither obligation nor accountability for the operation of the National Scheme as a whole”.

The AMA agrees with that statement. However, it does not agree that accountability should only be to the Health Ministers. It should also be accountable to the health practitioners who meet the costs of, and whose livelihood is determined by, the scheme.

The consultation paper proposes that the Australian Health Workforce Advisory Council (AHWAC) provide specific information to Health Ministers and their parliaments on the performance of:

- The regulators who oversee the work of the health professionals; and
- The health professionals themselves.

The AMA does not agree that AHWAC should be established to perform this role. Firstly, it is not sufficiently independent of the regulators to report on their performance. Secondly, it would not be sufficiently skilled to report on the performance of health professionals – on this point we note your advice at the consultation forum in Melbourne on 30 September that you do not intend that AHWAC perform this function.

We also note your advice at the same forum that the jurisdictions have asked that AHWAC provide state and territory specific reports on the performance of the regulators.

In addition, there is no description of how AHWAC would be supported in the role – what information it would have available to it, how it would obtain and use expert clinical advice, how its administrative support would be funded, and most importantly how it would engage the health practitioner stakeholders.

The AMA cannot see how the AHWAC role would actually increase accountability of the scheme in the way that is intended. However, if Governments want increased reporting on the regulators then they should meet the full costs of AHWAC.

**Performance of the regulators**

It must be acknowledged that the regulators should also be accountable to the health practitioners for their performance.

If medical practitioners don’t have confidence that their regulatory scheme is fair, timely, transparent and effective, how can the public be confident that the scheme deals with departures from practice standards and protects them from harm?

This aspect of the scheme must be appropriately led by the regulators.
Given that, under the National Law, AHWAC members are appointed by the Health Ministers, there may not be a sufficient level of independence in the assessment of performance, or accountability to the health practitioners.

Therefore, any performance reporting should include a process with the health practitioners, rather than performance reports being available to them after they have been provided to Health Ministers and tabled in parliaments.

The Australian Government has developed a framework for measuring and improving the performance of Commonwealth regulators\(^1\). Six key performance indicators (KPIs) have been developed to facilitate best practice regulator performance and administration.

Importantly, the framework also involves “external review” by a panel that includes a member of the “regulated community”.

Given that AHPRA and the Boards operate as national entities, it is appropriate that their performance be measured and reported under the framework for Commonwealth entities.

This would apply a more outward looking approach to measuring and reporting on the performance of the regulators and may even negate the need for AHWAC to be convened for this purpose.

The health professions should be consulted on the need for any additional KPIs that are appropriate for good health regulation that could be added to the Commonwealth Framework specifically for the regulators under the Scheme.

**Performance of the health professionals themselves**

Without any information about the nature or purpose of these performance reports, the AMA cannot not support any reporting of this kind to Health Ministers, much less through AHWAC.

If it is intended that these reports be a duplication of the activity and summary of outcomes of notifications that is currently contained in the AHPRA Annual Report, we cannot see the value of providing this information via AHWAC.

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**Question 1:** Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

**Response:** No. The Commonwealth *Regulator Performance Framework* offers a more independent approach to measuring and reporting on the performance of the regulators under the scheme that provides accountability to health practitioners. No case has been made for AHWAC to report on the performance of the health professionals themselves.

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**Workforce reform and access**

The consultation paper seeks to give AHWAC a wide reaching role in the health workforce reform agenda, but again, without any information about how it might undertake that role.

The AMA contends that it is not possible for an advisory group to have the dual aims of monitoring and reporting on the performance of the regulators of the health workforce and have a significant role in shaping health workforce reform.

The past 4 years has shown that the scheme is not the appropriate vehicle by which to regulate the health professions and to shape the health workforce of the future.

There is an inherent conflict of interest when the two functions are combined, which the past 4 years has also shown cannot be appropriately managed.

We agree that Health Ministers need to receive expert advice on the options for health workforce reform. Indeed, Health Workforce Australia (HWA) had been established for this purpose and had, over time, put in place structures and processes to ensure that key stakeholders were able to provide meaningful input into this advice.

**Part I: Reflections from the Independent Reviewer**

*Advice on proposals for changes in the standards being proposed*

In the submission to the review on 17 July 2014, the AMA described the situations where some health practitioner boards were acting as champions for their profession, rather than protectors of the public. It is disappointing that the review did not undertake any analysis of this to substantiate the proposal that AHWAC provide advice to Ministers on “proposals for changes in the standards being proposed” by National Boards.

Such an analysis might have positioned you to provide commentary on how AHWAC would assess proposals, the criteria it would use, the factors it would take into account, and how it would use expert clinical and health economist advice when formulating its own advice to Health Ministers.

In addition, the AHWAC role would be limited to advice on the standards – we assume because section 12 of the National Law only provides for Health Ministers to approve registration standards. The AMA has shown that some practitioner boards have selected other methods (e.g. guidelines, public statements) for championing expanded scopes of practice for their professions. The consultation paper does not address this.

**AHWAC reporting on action to improve access to services and delivery measured against workforce reform, including cross-profession initiatives**

It is a stretch to suggest that the scheme is a vehicle for improving access to services. In fact, the scheme is a vehicle for providing access to practitioners and for illustrating workforce distribution.

In terms of the workforce reform agenda, the scheme is critical because of its objective to protect the public by ensuring only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

In principle, it should do that by ensuring that scopes of practice of the health practitioners are underpinned by sound arrangements for:

- setting accreditation standards for education and training programs;
- assessing education and training providers against those standards;
- setting practice standards; and

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2 Paragraph 3(2)(a) of the National Law.
• assessment of practitioners for registration against those standards.

Conflating the role of the scheme to improve access to health care services with its role to protect the public, seriously compromises the latter. There should be no functionality within the scheme to actively pursue an agenda of “improving access to services”.

Each practitioner board should pursue the objective of protecting the public by maintaining and improving the quality of services provided by the health practitioners it regulates.

The AMA is very satisfied with accreditation for medical education and training. Australian trained medical practitioners are highly trained and skilled to international standards. It would be inappropriate for AHWAC to now interfere with this quality assurance arrangement under the guise of “improving access to services”.

AHWAC informs regulators about health workforce reform priorities and key health service access gaps
It is an interesting proposition that State and Territory governments are not currently able to articulate their views on health workforce reform to the regulator effectively via the Standing Council on Health, the Australian Health Ministers Advisory Council and the Health Workforce Principal Committee. It is not clear what value would be added for the regulators were AHWAC to act as the go between.

AHWAC assists in resolving complex policy issues involving multiple professions and stakeholders.
The AMA notes that under the scheme, the regulators have no role in policy setting. There is no discussion in the paper on the types of policy issues contemplated by the proposal, so it is unclear what is intended by this proposal.

Question 2: Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

Response: No. There is insufficient information on what would constitute an “unresolved” issue, how AHWAC would undertake this activity, or what authority AHWAC would have over regulators to comply with an AHWAC “decree”.

More discussion on the four proposals listed above is needed to convince the AMA that inserting AHWAC into the mix would make a material difference.

We reiterate our concern that as AHWAC members will be appointed by Health Ministers, in all likelihood on the advice of their departments, it will not have the desired independence and could therefore be used by governments to push the scheme in certain ways. That independence was put further in doubt when you said at the consultation forum in Melbourne on 30 September that AHWAC would be the voice of Health Ministers by providing advice to the regulators on how to implement health workforce reform. For that reason AHWAC would not be the panacea for improving how Australia reforms the health workforce to meet the future needs of the Australian community in an environment where governments are seeking to cap or otherwise limit funding of health services.

A truly independent body would not be driven by narrow government agendas and would be free to consult broadly with the professions in formulating its advice and opinions.
The AMA considers that the four proposals described above are an acknowledgement that there is no clear health workforce reform agenda that all governments have committed to and are pursing in a consistent way. This is exacerbated by the fact that the Commonwealth has abolished HWA. Unless the Department of Health fully takes on the functions of HWA and engages effectively with stakeholders, we are in danger of going back down the road where all workforce planning was undertaken by the jurisdictions, without proper input from the medical profession and the other practitioner groups.

Neither the scheme nor AHWAC are the vehicles by which to fill this void.

**Part II of the consultation paper**

The proposition that “priorities for workforce reform, innovation and access to services be determined in the scheme” suggests that the agencies within the scheme should have a proactive role in health workforce reform. The AMA disagrees, and argues strongly against this being included in the scheme and the National Law.

It is therefore pleasing that the review reports that “most agencies did not see a role in driving reform”. The concern then is that some agencies have taken a different view.

The AMA contends that the objective in paragraph 4(2)(f) of the National Law to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners, puts the cart before the horse.

Most of the recent proposals for workforce reform, under the guise of proposals for expanded scopes of practice, purport to fill a gap in access to medical services. This ignores the fact that measures have now been taken to address the serious undersupply of medical practitioners that was created by governments past.

In 2018 there will be 3,796 medical graduates, a 195 per cent increase on the 1,287 graduates in 2004. Therefore many workforce reform proposals pretend to address a problem that has already been addressed.

Consequently, there is an urgent need for an independent entity to be set up to assess and evaluate health workforce needs in the context of the health needs of the Australian community and the expenditure on health that the Australian community is prepared to pay.

Within that structure, expanded scopes of practice could be assessed to determine that:

- the required competencies are predetermined and accredited training and education programs are available to deliver those competencies;
- there are documented protocols for collaboration with other health practitioners;
- there are no new safety risks for patients;
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.
The assessment group should comprise the following members:
- a Chairperson who is a non-practising clinician;
- a specialist general practitioner;
- a specialist medical practitioner;
- a nurse;
- a former President of a Medical College;
- a community member; and
- a health economist.

A member of the health practitioner group that is the subject of the assessment would be a temporary member of the assessment group, as would any other registered health practitioner group that would be affected by the proposal.

The independent entity and the assessment group should have appropriate administrative support and be able to access specific clinical and health economic expertise as required. The assessment group should be able to receive proposals for expanded scope of practice, and initiate assessments where necessary. All assessments by and advice of the assessment group should be made publicly available.

Because of the impact on health budgets and the implications for the safety and quality of the Australian healthcare system, this assessment and evaluation process should be funded by governments. It is not necessary to have a legislative basis for this entity. There are several examples of non-legislative entities that are jointly funded by all governments.

While Health Ministers would be responsible for appointing the members, its independence would be secured through the public reporting mechanisms described above and not to the Health Ministers. This would mean that Health Ministers, in ignoring the advice of the independent entity, would be taking a political decision to do so.

In this context, the role of the health practitioner boards would be, as is their current role, to:
- ensure the relevant accreditation council sets new education and training standards and accredits education and training programs that deliver the required competencies;
- approve the education and training programs;
- set appropriate registration standards;
- permit only those practitioners who meet the registration standard to practice in an expanded scope.

In the meantime, health practitioner boards should be required to issue public statements addressing all of the matters listed above when they decide to expand scopes of practice, whether by standards, guidelines or fact sheets or indeed through no action at all.

The AMA accepts that the National Law regulates title and not scope of practice. We accept that a move to regulate scopes of practice could have unintended consequences, for example by limiting legitimate practice in certain circumstances, such as within clinical units in public hospitals that have tightly defined clinical protocols in place.

However, it is critical that Australia move now to a proper and sensible approach to developing a health workforce for the future.
We must not allow self-determined expansions of scope of practice to continue to go unchecked under the pre-text that paragraph 4(2)(f) of the National Law confers some greater role on the agencies in the scheme that they are not adequately equipped to perform.

**Question 20:** To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsible and sustainable health workforce, and innovation in education and service delivery?

**Response:** The AMA does not agree that the National Boards and Accrediting Authorities should have such a proactive role in health workforce reform.

**Question 21:** Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service gaps?

**Response:** This question implies that, having been informed of health workforce priorities and key health services gaps, regulators within the scheme are directly responsible for addressing them.

Other processes are required to assess and advise on solutions to these issues, in conjunction with the Standing Council on Health, the Australian Health Ministers Advisory Council and the Health Workforce Principal Committee, and perhaps a new independent entity.

Health Ministers should be capable of articulating health workforce reform measures.

If regulators in the scheme are clear that their core responsibility is practitioner regulation, and not to drive health workforce reform, they will understand how to respond.

**Question 22:** To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health care needs?

**Response:** This question should have been evaluated in detail by the review. The AMA notes that there has been a long standing working relationship between the AMC and the Dental Council to accredit the Oral and Maxillofacial surgical training program. The AMA is also aware that the AMC is involved with and provides advice to the Health Professions Accreditation Council Forum.

**Question 23:** What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

**Response:** For medicine, the relationship between the MBA, the Australian Medical Council and the universities works well. The AMA accepts that for medicine, there is room for both under-graduate and post-graduate streams for entry to medical school. The AMA would not accept any lowering of academic standards for medicine. Further, there should be no attempt to dilute the current guarantee of quality of professionalism and practice that a medical degree confers on medical graduates. This is a direct factor of the education and training they receive during their university education, not what qualification they already possessed on entering the university course.
The future of regulation of health practitioners in Australia

*Level of regulation*

The AMA does not agree with the proposition that the health practitioner groups that are low in number and are unlikely to cause harm, are necessarily over-regulated, or that regulation is “disproportionate”. The relatively low number of complaints about these practitioners can be a factor of their role and position in the multidisciplinary care team. Consequently they may be less noticeable as contributing to an unsatisfactory service or an instance of harm.

Case law after case law shows that most adverse events have more than one contributing factor and more than one contributing health practitioner. A failure by the pharmacy clerk to order the correct contrast medium ends with an adverse outcome from colonoscopy. In these types of cases it is never known whether notifications were made about the pharmacist or the nurse that also played a part in the failure to deliver the correct contrast medium to the patient. We know that medical practitioners work in systems that can fail them and their patients.

Consequently, the number of complaints or notifications made is not an appropriate way to measure the risk of harm. This is why the AMA’s stance on expanded scopes of practice is so strong. Not for turf protection, but for patient safety.

*Establish a Health Professions Australia Board*

There is a fixed cost to setting accreditation and registration standards. There is a risk that if these standards are set for nine health professions by one board, eventually there will be a “harmonisation” of practice. At this point it time this does not seem to be a sensible path on which to embark on a journey of health workforce reform.

The consultation paper states that this has successfully occurred in the United Kingdom. It may have occurred, but by what metric has it been judged to have been successful?

In addition, the AMA believed that the purpose of a national scheme was to achieve economies of scale in the administrative function. It is not clear how this can be further rationalised within the system.

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<th>Question 3: Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?</th>
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<td><strong>Response:</strong> No. There is risk that this will lead to a harmonisation of accreditation and registration standards that will not be appropriate in the context of an agenda of health workforce reform.</td>
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<th>Question 4: Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service?</th>
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<td><strong>Response:</strong> The AMA understood that the national scheme was specifically designed so that all the National Boards shared the regulatory functions of notifications and registrations through a single service provided by AHPRA.</td>
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Question 5: Should the savings achieved through shared regulation under options 1 or 2 be returned to registrant through lower fees?

Response: Yes.

Other professions entering the scheme
The AMA does not support other health practitioner groups, or health care workers, joining the scheme, merely to enjoy a perceived status and credibility of being regulated by the scheme. Any mis-perception by health entities that not being regulated by the National Law “disqualifies” the other health practitioner groups from particular benefits needs to be addressed through information which explains that the scheme deals with the professions that have higher safety risks.

Only those that have a scientific basis to their practice should be included in the scheme.

Much work has already been devoted to developing a National Code of Conduct for the health care workers to be governed by State and Territory health care complaints entities. This should be implemented as planned. If there is some concern by governments about the cost of administering the code of conduct mechanism, it could consider a system of health care workers paying an application fee to be “recognised” as a practitioner who practises according to the code of conduct, which would give them a market advantage.

Other avenues of redress are available, namely the consumer protection laws, small claims courts and legal suits.

Question 6: Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

Response: No. Only those practitioner groups with a scientific basis to their training should be included in the scheme. All other health care workers should be subject to a jurisdictional based code of conduct mechanism.

Question 7: Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory mechanisms?

Response: No. This would give health care workers undue status and credibility. It would also add unnecessary layers to the arrangements for dealing with complaints about these practitioners. The state based health care complaints entities, consumer laws and the courts all offer protection for dissatisfied consumers.

Question 8: Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

Response: No. The Australian Health Ministers’ Advisory Council should be sufficiently placed to perform this function.
**Question 18:** In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

**Response:** The report on the consultation on the National Code of Conduct should identify what legislation is needed to support the proper implementation of the Code to protect the public from risk of harm from (the large group of) unregistered health practitioners.

**Complaints and Notifications**

The review is deficient in that it has not considered the impact of the scheme on the practitioners it regulates. There is no recognition of, or findings about, how practitioners have been unduly affected by unfair and protracted investigations and from improper up front handling of vexatious matters. The review has not considered the personal and financial costs to practitioners who have been the subject of notifications and inappropriately directed complaints.

The review should have considered:

- the degree to which matters are handled in a timely way from the practitioner’s perspective – while strict timelines can impede good processes, lengthy delays affect the well-being of practitioners while they await the next phase of their matter;
- whether there is equality in the process – where AHPRA takes 6 months to progress a matter to investigation, the practitioner must respond in 14 days;
- how transparent and fair the process is to practitioners – practitioners are unable to respond appropriately to matters because they are currently denied access to the material that the investigator and the Board are using to make decisions;
- if vexatious complaints are appropriately identified and dealt with – prospective litigants are using the scheme as a cost free method to decide if there is sufficient basis for a legal suit. Similarly, employers are notifying matters that should be dealt with by organisations as industrial or human relations matters.

The AMA agrees with the statement in the consultation paper that:

“a notifier is similar to a witness who brings their concerns to the attention of the regulator”.

As we have stated above, there are many mechanisms available to patients to pursue their dissatisfaction, complaint or grievance. The fact that “consumers” make a complaint to the scheme in the belief that they will have a personal resolution is not a failure of the scheme. It is a failure to educate the public and assist them pursue the appropriate avenue.

The scheme should not be redesigned on the misdirected and condescending view that the public is not able to understand the differences between the scheme and complaints arrangements.

Upon receiving a notification, the regulator must be focused on making the right assessment of the situation, conducting the most appropriate and efficient investigation, and deciding on the most appropriate remedy for the practitioner to protect the public from harm. It must be remembered that it is important to keep highly trained and skilled people in the workforce.
The regulator must not be distracted from the task of arriving at the most appropriate outcome for the health care system, to instead focus on satisfying the individual who has made the notification.

To suggest the scheme has an obligation or a role to satisfy the individual is to undermine the purpose of the scheme and where it sits in the entire system of complaints resolution, open disclosure, self-regulation and legal processes.

We do not know how much of the individuals’ dissatisfaction was borne out of the delays that can occur. For example, a person who is advised nine months after making a notification to the scheme that their complaint has been referred to the HCE for action is likely to be dissatisfied with the outcome because they now face another wait for the HCE to process their matter.

The triaging of complaints to HCEs and notifications to the boards is the key to a timely and effective scheme, from both the public and the practitioners perspectives. The AMA would be very pleased to provide senior and respected medical practitioners to work closely with AHPRA and the MBA to improve the triaging arrangements. Minor matters must be dealt with quickly and early, to address the public’s concerns and minimise the impact on the practitioner’s wellbeing.

Health practitioner regulation is resource intensive. An investigation must often cover a lot of ground that includes interrogation of clinical and hospital records. Resources cannot be diverted to satisfy the misplaced expectation of an individual.

**Options and impact analysis**

Again, it is disappointing that the review has not undertaken any analysis of the information within the scheme to support any of the options proposed.

Within options 1 and 2 the AMA cannot support:

- notifiers becoming more integral to the process and provided with information at each step of the process, including the outcome and reasons for the decisions that led to it;
- providing AHPRA and the National Boards with the ability to utilise an alternative dispute resolution service;
- locate the receipt and assessment of all notifications within the State and Territory HCEs; and
- locate powers to investigate and take action in serious disciplinary matters with HCEs and given them discretion to refer matters to National Boards and AHPRA to manage.

The history of practitioner regulation is littered with regulatory changes that have been quickly introduced on the back of high profile, and usually isolated, cases. Health Ministers have been quick to make these changes without any assessment of where the ineffectiveness and inefficiencies lie. This is an inadequate (and expensive for health practitioners) way to solve unquantified problems. As we have already stated, no scheme can or will be judged to be perfectly effective.

The AMA notes that none of the problems that these proposals seek to address have been specifically identified, quantified or costed by the review. We also note that the costs of the
new arrangements in Queensland are still not known and its effectiveness is unlikely to ever be properly measured.

It is time that there be a full and proper study of where and how the scheme can be made more effective and efficient. Adding new “customer” focused dimensions to the scheme is misdirected. It is unfair to ask registrants to fund this activity.

Registrants need to know that the scheme is as efficient and fair as it can be.

“Consumers” need to be reassured that the scheme is robust in protecting the public in the manner it is designed to do. They need to be informed about all their avenues for redress.

The paper does not fully explore the purpose of the public register and the use of the information by patients in selecting their health practitioners. As the scheme is in effect a licensing scheme, the public register should only contain information about the practitioner’s current practice restrictions.

The extent to which prior conduct is published needs greater discussion with the community. Where a practitioner has previously been the subject of disciplinary action and has remedied their practice such that the Board has permitted him or her to return to full practice, this should be reassurance to the community that the scheme is effective.

The public register is not, and should not be, the only avenue by which patients obtain information about prospective health practitioners. Professional referral arrangements, word of mouth and social media are all valuable tools for patients.

**Question 9:** What changes are required to improve the existing complaints and notifications system under the National Scheme?

**Response:** There should be a clear statement that the scheme is a notifications scheme and that the role and standing of the notifier is limited to bringing concerns to the attention of the regulator. Strategies for ongoing education of “consumers” about avenues for redress. The Boards, and their registrant stakeholders, AHPRA and HCEs should work together to make improvements to the process for triaging complaints and notifications and to the process for managing and completing notifications.

**Question 10:** Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

**Response:** No. Complaints should managed by an independent health care complaints entity. The Queensland co-regulatory model that includes notifications is not yet proven, and the costs are as yet unknown.

**Question 11:** Should there be a single entry point for complaints and notifications in each State and Territory?

**Response:** We need to have a better understanding why the current arrangements can’t be improved, because shifting the same problem to a different entity will not resolve the problem. How would a single entry point operate differently to the current arrangement to be more effective and efficient at triaging complaints to HCEs and notifications to the scheme?
**Question 12:** Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

**Response:** No. Performance measures should be adopted, but strict timeframes come with a risk that poor processes will be used to meet arbitrary timeframes at the expense of the right outcome. Performance information would provide some information about the capacity and efficiency of the scheme. However, we are cautious about agreeing to prescribed timeframes until we know that the scheme is well placed to commit to them. AHPRA is not meeting the KPIs now. The KPIs could be inappropriate. Or AHPRA could be under resourced, or inefficient. The concern is that when prescribed timeframes are not met, the health practitioners will be asked to fund more resources. Instead health practitioners should be involved in an ongoing process with AHPRA and the Boards to continually refine and improve the scheme and identify and remove unnecessary bureaucratic layers.

**Question 13:** Is there sufficient transparency for the public and for notifiers about the processes and outcomes of disciplinary processes? If not, how can this be improved?

**Response:** The AMA advocated for AHPRA to write a guide to notifications so that the process was transparent to practitioners and the public and to ensure the AHPRA staff followed the correct processes. This document will always benefit from periodic review and improvement to make the scheme more transparent and more efficient.

In terms of transparency of outcomes of disciplinary process, notifiers should have no right to more information about the outcomes for individual practitioners than the general public does through the public register.

**Question 14:** Should there be more flexible powers for the National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

**Response:** No. The notifier does not, and should not have standing in the disciplinary process. Disciplinary action by the Board is not a matter of negotiation with the notifier. The Board must make a decision that the practitioner has departed from accepted practice and that there is a risk of harm to the public on the facts – the Board’s duty of care is to the public, not the individual notifier. Dispute resolution is offered through HCEs and litigation.

**Question 15:** At what point should an adverse finding and the associated intervention recorded against a practitioner be removed (from the public register)?

**Response:** For medical practitioners, adverse findings in relation to matters proven on the basis of rules of evidence, a rigorous evidence base and due process, comparable to those applying in court proceedings can be permanently published. There needs to be more discussion about where this is published. Allegations and unproven matters should not be published. Disciplinary sanctions such as suspensions, conditions and undertakings should be published on the public register while they are current i.e. until the Board has permitted the practitioner to return to full practice.
Advertising

Testimonials
The issue of testimonials and advertising was addressed to the satisfaction of the medical profession earlier this year. There is no need for the review to reconsider this issue.

Cosmetic procedures
The AMA agrees with the statement that “The regulation of cosmetic medicine and surgery is complicated”. The AMA made a detailed submission to the Medical Board on the issue last year. It is preferable that this work continues in a focused way and not part of the review.

Options for advertising provisions
Again it is disappointing that there is no identification or quantification of the “problems” that are intended to be addressed by the proposed options.

The consultation paper states that 60 per cent of all alleged offences related to breaches of the advertising guidelines. This may not mean there is a problem with the advertising guidelines. It may mean that the scheme is effective in its compliance activities.

Therefore, the AMA cannot comment on the options.

Question 16: Are the legislative provisions on advertising working effectively or do they require change?
Response: The consultation paper does not provide sufficient analysis of the impact of the current arrangements to be able to answer the question.

Question 17: How should the National Scheme respond to differences in States and Territories in protected practices?
Response: The practice of medicine and that of other health practitioners will always be subject to individual jurisdictional laws. There is not sufficient discussion in the paper to provide any detailed comment.

Mandatory notifications
The AMA has long advocated for treating practitioners to be exempted from the mandatory reporting requirements and supports the removal of such requirements already enacted in Western Australia and Queensland. It is critical that health practitioners are not deterred, for any reason, from seeking early treatment for health conditions.

The inconsistency across the jurisdictions regarding mandatory reporting by treating practitioners is therefore an inherent problem.

The review notes that the variation in the Western Australian law does not appear to have made a material difference to the rate of mandatory notifications. Further, the fact that the review – with access to the relevant information – is unable to make a finding about the impact of this inconsistency on public safety illustrates that there is no compelling reason to continue enforcing mandatory reporting by treating practitioners.
The AMA notes that Bismark et al (MJA 201(7) 6 October 2014) was similarly unable to interrogate data provided by AHPRA to determine that the exemption in Western Australia was detrimental to public safety. Bismark found that 92% of mandatory reporting was made by fellow colleagues and employers.

To date, no evidence has been produced that shows that the subjects of mandatory reports made by treating practitioners were not already the subject of a notification (either mandatory or voluntary) by a work colleague or an employer. Consequently, the case has not been made that the requirement on treating practitioners outweighs the need to ensure health practitioners seek early treatment for their health conditions.

There is no reason to maintain the mandatory reporting requirement on treating practitioners.

**Question 19**: Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

**Response**: The Section 141 of National Law should be amended to exempt treating practitioners from the mandatory reporting requirements by inserting the following paragraph in the Schedule after section 141(4)(c):

(da) the first health practitioner forms the reasonable belief in the course of providing health services to the second health practitioner or student.

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**Assessment of overseas trained practitioners**

The AMA is satisfied with the current arrangements for the assessment and supervision of overseas trained medical practitioners.

The Medical Board of Australia (MBA) has a National Specialist Committee for overseas trained medical practitioners. The Committee provides advice and recommendations to the MBA on the nationally consistent assessment pathway for overseas trained specialists. This established process is the most appropriate avenue for monitoring the arrangements and their operation.

**Registration delays**

In response to the *Lost in the Labyrinth Report*, the Australian Medical Council (AMC) and the MBA have implemented improved processes to address the key issues raised. The AMC also opened the National Test Centre for AMC examinations, to improve the availability and efficiency of the examinations for overseas trained medical practitioners seeking general registration in Australia and has further developed the Workplace-Based Assessment pathway as an alternative to the Standard pathway.

**Area of need (AoN) and district of workforce shortage (DWS)**

While registration processes for overseas trained practitioners are linked in some circumstances to AoN, DWS is a Commonwealth workforce measure largely linked to Medicare provider number access and various workforce incentive programs.

The scheme is able to inform these workforce initiatives, because it can provide decision makers with information about current workforce distribution. There should be no greater role for the scheme on these matters.
Costs
The requirement to have a PESCI is risk based and does not apply in all circumstances as the consultation paper suggests. In the absence of the Government funding the PESCI process, there is no alternative but for the applicant to cover these costs. PESCs, by their nature, are a costly process. The costs for PESCs for overseas trained medical practitioners should not be met by the registration fees paid by all doctors.

Question 24: How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

Response: The current arrangements for assessment and supervision of overseas trained medical practitioners are effective and have been developed through extensive consultation with stakeholders, including employers. The MBA’s established processes are the most appropriate avenues for monitoring the standards and their operation.

Proposed changes to the National Law
The AMA’s comments on proposed changes to the National Law appear in Attachment A.

Conclusion
The AMA is not satisfied that the Review has sufficiently examined the efficiency and effectiveness of the scheme, and therefore provided sufficient justification for the proposed changes. If the Review makes any recommendations for change, they must be subject to a more detailed analysis, backed by actual data from the scheme, before any of them are implemented.

After four years, the scheme needs to be bedded down so that it provides a timely, fair, efficient and effective process for departures from practice standards. Improvements can only be made by analysing current processes and the outcomes of cases.

There is no justification provided in the review for making wholesale changes, such as increasing the standing of notifiers in the investigation process or in the decisions by the Board on outcomes, or by having HCEs deal with the more serious matters, without first making a concerted effort to improve current processes. To do so would simply shift the same problems to a different entity.

Finally, the scheme is not the appropriate vehicle to drive health workforce reform. Health Ministers must ensure that the void filled by the abolition of HWA is replaced by an entity that is independent of the practitioner regulation arrangements.

In summary:
- Health workforce reform must be developed and managed outside the national scheme. The proposal that AHWAC be the driver of health workforce reform is not acceptable to the AMA. AHWAC will not be sufficiently independent of the health practitioner regulation scheme to be able to provide the appropriate advice to Health Ministers on health workforce reform to ensure Australia develops the health workforce it will need;
- The health practitioner regulation scheme must remain a notifications/disciplinary model and not become a consumer outcome/dispute resolution process. The regulators must focus on protecting the public, not providing resolutions for individuals. The state based health complaints entities are well placed to deal with
health care complaints from individuals who desire an individual resolution. Improved triaging of notifications and complaints is needed;

- The scheme must be fair, timely, transparent and effective if it is to have the confidence of the professions it regulates and the general public. A concerted effort is needed to undertake a proper analysis and identification of the ineffectiveness and inefficiencies within the scheme – with the profession – to improvement the scheme. Now is not the time to be recommending alternative, and unproven, arrangements.

Yours sincerely

A/Prof Brian Owler
AMA President

10 October 2014

Dr Bill Meyers
Federal President
Australian Medical Acupuncture College (AMAC)

Professor Simon Carney
President
Australia and New Zealand Rhinologic Society (ANZRS)

Professor Peter Choong
President
Australian Orthopaedic Association Limited (AOA)

Dr Nigel Stewart
President
Australian Paediatric Society (APS)

Associate Professor Peter Molenaar
President
Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT)

Dr Arthur Karagiannis
President
Australian Society of Ophthalmologists (ASO)

Dr Joanne Dixon
President
Human Genetics Society of Australasia (HGSA)

A/Prof Wendy Brown
President
Obesity Surgery Society of Australia & New Zealand (OSSANZ)
Proposed changes to the National Law

The AMA notes that the proposed amendments to the National Law match those that were the subject of consultation by the Queensland Health Department in August 2011. If the Health Ministers have already approved these amendments, it is not clear why we are being consulted again.

Having said that, some of the amendments listed under Other Amendments in the consultation paper got to the heart of the discussions about triaging complaints and notifications, the standing of the notifier, the information to be provided to notifiers about the progress of the matter and the outcomes, and the information to be provided to the person who is the subject of the notification. While we have provided comments against the proposed amendments below, on principle, none of those amendments should be made until there is full and proper consultation on the recommendations from the review itself.

Commonwealth reforms to Freedom of Information (FOI) Legislation

The consultation paper suggests that adopting the reformed Commonwealth FOI legislation would be limited to recognising the new titles for the Information Commissioner and the FOI Commissioner.

However, we expect that all of the reforms contained in the Freedom of Information Amendment (Reform) Act 2010 will be adopted. This would include:

- the measures to remove application fees and reduce the costs of requests; and
- the new provisions that require proactive publication of information by agencies, such as the operational information held by the agency to assist the agency to perform or exercise the agency’s functions or powers in making decisions or recommendations affecting members of the public. It is appropriate that people who are the subject of regulatory decisions made under the National Law are able to access the operational documents that the decision makers use. This is particularly important for people who may not be able to earn a living as a result of these decisions.

Publication and tabling of regulations

The AMA supports the amendment that would require the jurisdictions to table in Parliament, publish and notify the public of regulations under the National Law in the same way that other regulations in the relevant jurisdictions are tabled, published and notified.

However, we do not support retaining the requirement for the majority of disallowances in all jurisdictions (other than Western Australia). This requirement provides very little chance of individual Parliaments having sovereignty over the National Law in their own jurisdiction. The AMA made this point in several submissions during the development of the National Law.

Statutory protection for health practitioners reporting serious offences to police

In principle, the AMA supports the amendment to provide protections for health practitioners reporting serious offences to police. However, we seek further information about how this provision will apply in practice. For example, in some jurisdictions medical practitioners are required to report cases of child abuse, and it would be useful to know how these laws will operate concurrently.
**COAG Standing Council on Health**

We note that the National Health Reform Agreement defines the Standing Council on Health as being the “forum established to facilitate the provision of advice by Health Ministers to COAG”.

We have no objection to the COAG Standing Council on Health being the Ministerial Council for the purposes of the National Law if the Standing Council is comprised of Health Ministers, i.e. it is change in name only.

The AMA is of the view that the New Zealand Health Minister should be excluded from decisions taken by the Health Ministers under the National Law.

**Other amendments**

*Section 149(1)(c) (Preliminary assessment)*

In principle, the AMA agrees it would be appropriate to clarify the actions a Board can take once it has made a preliminary assessment of a notification.

However, the nature of those actions needs to be better understood in the context of the co-regulatory arrangements in NSW and Queensland, and as a result of any recommendations that are implemented as a result of the review.

The AMA also notes that paragraph 149(1)(c) does not exist in the National Law in Queensland.

*Section 151 (When a National Board may decide to take no further action)*

In principle, the AMA agrees it would be appropriate to clarify the circumstances in which a Board may decide to take no further action after a preliminary assessment of a notification.

*Section 167 (Decision by National Board after considering the investigator’s report)*

*Section 177 (Decision by National Board after considering the assessor’s report and the discussions held with the registered health practitioner or student)*

In principle, the AMA agrees that notifiers should be advised that a matter has concluded, and in very broad terms what the nature of the outcome, as per information that is included on the public register. The legislation does not need to be amended to support reasonable administrative action.

However, because the Board cannot control what the notifier does with information that the Board provides, the practitioner’s personal information must not be divulged to the notifier and the legislation should explicitly preclude this. Consequently, any information given to the notifier by the Board must be on the basis that it could be made public and therefore must be limited to broadest possible terms.

Given the earlier discussion in the consultation paper and this submission about the standing of the notifier, the medical profession must have agreement with the MBA and AHPRA about the extent of the information about the practitioner that would be provided to the notifier as part of the reasons for the decision, and for this to be fully documented in the operational information that supports decision making by the Board and AHPRA.

Consideration must also be given to whether it is relevant for different information to be provided, for example if the notifier is the practitioner’s employer.
Further, the practitioner must be provided with a copy of the information given to the notifier.

The AMA supports the amendment to s.177 for a board to give written notice to a practitioner or student about the board’s decision in respect of a health assessment or performance assessment the practitioner. However, the amendment should include an explicit requirement for the board to provide reasons for the decision in the written notice.

Section 180 (Notice to be given to health practitioner or student and notifier)
The AMA notes that the consultation paper does not describe the proposed amendment.

For the reasons provided above in relation to information given to notifiers, the AMA seeks discussions with the Medical Board and AHPRA to determine the parameters of the reasons for all Board decisions being provided to notifiers, before it can support any amendment to section 180.

Time-frames for taking proceedings for offences
In principle, and in fairness to registrants, the AMA recognises the need for standardised time-frames for alleged offences under the Act to proceed to court.

However, we cannot agree to the proposal to set the timeframe under the National Law to 24 months until information is provided by AHPRA about what the current timeframes are, and an analysis of how matters could be dealt with more efficiently.

Further legislative amendments proposed by AHPRA and the National Boards

Commencement of registration
As the paper does not provide any information about the circumstances when it would be valuable for a board to commence registration on a dates to be determined, or why this mechanism is particularly relevant if other health practitioner groups join the scheme, the AMA cannot support the proposed amendment.

Multiple registration subtypes including limited registration
More information is needed to understand how this amendment would work in practice, for each of the health professions. The dentistry example provided is not informative for medicine.

Contravention of undertakings
The AMA cannot support the amendment, in the form proposed, which would allow the Board to refuse to renew an applicant’s registration if they failed to comply with an undertaking.

The AHPRA website clearly states that “An undertaking is voluntary, whereas a condition is imposed on a practitioner’s registration”.

Again, we note an absence of any supporting evidence that the amendment is necessary. Therefore, the AMA considers it would be appropriate that the registrant be given an opportunity to explain the circumstances of their failure to meet an undertaking, and for the Board to take that into account when deciding how to deal with the failure.

The AMA notes that a Board can impose a condition of registration, which is a more strident restriction of the practitioner’s practice.
Until there is further discussion with the profession on the use of undertaking as a disciplinary measure, the AMA cannot support imposing a sanction that would render undertakings to have the same effect as conditions.

Actions following suspension
In the interests of procedural fairness, there should be an avenue under the National Law for the Board to end any suspension that it has imposed under s.156 (immediate action), or other provisions.

The AMA agrees that the National Law should permit a practitioner to renew their registration if the renewal falls during a period of suspension. This would allow the practitioner to return to practice at the end of the period of suspension without having to make a new application for registration.

Information on the Register
If there are situations where the inclusion of certain information on the National Register can have a detrimental effect on a third party, as suggested in the consultation paper, in principle the AMA would support the Board excluding that information.

Conditions on registration
In principle, the AMA support the proposal to give the Boards the power to accept an undertaking from a registrant, rather than only by imposing conditions to achieve an intended purpose. However, we first need to understand how this proposal would work in practice given the earlier proposed amendment that practitioners’ registration not be renewed if they fail to act on their voluntary undertaking.

In supporting this proposal we recognise that undertakings are published on the National Register.

In the interests of procedural fairness, the AMA would support in principle, the inclusion of a review period to be set where conditions are amended under sections 125 and 126.

Abrogation of right against self-incrimination
There is a lack of clarity in the consultation paper around this proposal, including a sentence fragment and missing information.

We seek further detail on the proposed changes and the reasons for them, including information about how this provision will apply in practice and the expected impact on notification timeframes.

In principle, we would support improved protections for practitioners to encourage open engagement and discussion on issues under consideration by the Board. In theory, these protections should support efficiencies in the investigation of notifications.

Notice requirement at Section 180
The AMA agrees with amendments that require Boards to provide written notice of reasons for any decisions it makes to the practitioner who is subject to the decision.

However, based on our comments above in relation to the proposed amendment to the same section, we want to have a discussion with AHPRA and the MBA about the information the notifier would receive.
As stated above in response to proposed changes to sections 167 and 177, the AMA supports advising notifiers in a general way that a matter has concluded, and in very broad terms what the nature of the outcome was, and without divulging the patient or the practitioner’s personal information or the potential impact on a third party.

Once written information is provided externally, AHPRA has no control over the use of the information. A longer term consequence will be increased cautiousness amongst practitioner in sharing their version of events, in the knowledge there may be no controls over how the information might be used down the track. A more adversarial investigation process will result and consequently poorer outcomes for notifiers and practitioners under review.

Consideration must also be given to whether it is relevant for different information to be provided, depending on whether the notifier is a patient of the practitioner or a third party.

Further, it would not be appropriate for any personal information about the practitioner to be provided to the notifier, and the legislation should explicitly preclude this.

It is unclear how the proposal to give written notice of all decisions under Division 10 would affect the earlier proposal for *abrogation of right against self-incrimination*, given that AHPRA will have no control over the use of information provided externally in written decisions.

**Appellable Decisions**

The AMA support the inclusion of a time frame for practitioners to make an appeal to the responsible tribunal. However, to allow reasonable time to respond we propose a nominal 60 day time limit on appeals, instead of the proposed 28 days.

In addition, we note s.199 *Appellable Decisions* does not include reference to cautions or undertakings. In 2012-13, 180 cautions were issued to medical practitioners (excluding NSW). As medical practitioners are required to disclose any findings of the Medical Board to their employers, cautions and undertakings issued by Boards and performance and professional standards panels should be appellable, as is the case with reprimands.

**Obtaining information from other government agencies**

AMA members have reported receiving unreasonable demands for information from AHPRA investigation officers, including an example that exceeded the authority afforded to investigators under the legislation. Such demands have been made without explanation of how the information would be used or the context of the AHPRA investigation.

In the interests of transparency and procedural fairness, the powers of investigation officers need to be managed under a procedural framework and clearly set out in the *Guide for Practitioners: Notifications in the National Scheme*. 

Until there is evidence that AHPRA has clear and robust procedures in place to guide and monitor the activities of its investigating officers, the AMA cannot support the proposal to afford more powers to investigators to obtain information from additional agencies than those already covered in the National Law.

**Notice of a decision to take action**

In principle, the AMA support the proposed amendment to notify all places of practice, making it clear that s.206 applies equally to contractual arrangements.