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Mr Richard Willis  
Secretary  
Legal & Social Issues Committee  
Legislative Council  
Parliament House  
EAST MELBOURNE VIC 3002

19 July 2013

Dear Mr Willis

**Re: Inquiry into the Performance of the Australian Health Practitioner Regulation Agency Supplementary information resulting from evidence given on 26/6/13 in response to your letter of 28/6/13**

The Australian Doctors' Fund thanks the Committee for hearing its representation and is pleased to provide supplementary information as requested and to clarify any issues raised as a result of the ADF's presentation.

Request for corrections need to be made to Hansard

Page 5. Mr Milgate responding to Ms Hartland, 2<sup>nd</sup> last line, the word 'different' is wrong. It should be difficult (i.e. change different to difficult)

Page 5. Mr Milgate responding to Ms Hartland, last line, the word 'or' should be 'for' (i.e. parliamentary accountability for anything that AHPRA controls)

Page 5, line 7. Mr Milgate responding to the Chair. Between the word 'any parliamentary' insert the word 'direct' i.e. any direct parliamentary redress (see further comment at line 12 where the term 'direct parliamentary accountability' is used)

Page 7. Mr Milgate responding to Mr Viney, 1<sup>st</sup> line, the words 'I never said' is wrong. It should be 'I have never said' (i.e. insert have)

Your request for further information

**State Health Minister's ability to deal with a complaint referred to him/her by a local Member of Parliament, together with Parliament's ability to disallow a regulation.**

Response: The ADF draws the Committee's attention to the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (IGA) which underpins all legislation concerning the Scheme and sets the rules as to how the Scheme will be run and who will run it.

1. **This agreement appoints at Part 7 the Ministerial Council (AHMC).**

At 7.1, “The Parties shall establish in legislation the Ministerial Council to be known as the Australian Health Workforce Ministerial Council and will comprise the Commonwealth Health Minister and the Ministers with responsibility for Health from each State and Territory.”

At 7.4, **“Agreement by the Ministerial Council for the purpose of decisions relating to this scheme will be by consensus.** In circumstances where the Ministerial Council is unable to come to an agreement and a decision must be made, there will be a transparent process of review in order to assist it to reach an agreement. This review will be undertaken by the Advisory Council.”

At 7.5 (c), “proposing legislative amendments through processes of governments, which are consistent with this Agreement”

At 7.5 (f), “appointing members of boards”

At 7.8, “To clarify, the Ministerial Council will not seek to insert itself into the day-to-day operations of the national agency. In particular, **the Ministerial Council will not have any power to intervene in registration, examination or disciplinary decisions relating to individuals, or decisions relating to the accreditation of specific courses.**”
2. At the Senate Standing Committee of Community Affairs on 7/5/2009, The Project Director of the National Registration and Accreditation Implementation Project, Dr Louise Morauta described the governance process of the scheme as follows, **“Yes, It is quite a complicated structure. For example, if anything is amended, all the ministers of all the jurisdictions in the IGA have to agree before the amendment goes off so you do not get a situation where somebody has an idea on his or her own and puts it in. The IGA says that they have to agree with what is going on. It is sort of underpinned by the IGA.”**
3. When asked about the accountability of the Boards, Dr Morauta told the Senate, **“The Boards are accountable to ministers; it’s just that they are accountable to multiple ministers.”**
4. The Health Practitioner National Law (Victoria) clearly states at 288.2, **“from the participation day the complaint or notification is taken to be a notification made under this law to the national agency”.** i.e. all notifications henceforth are notifications to AHPRA and come under AHPRA’s management system. NSW and now Queensland have opted out of this complaints process.
5. Under the scheme, AHPRA manages notifications, but does not make decisions on the notifications. **“AHPRA is responsible for assessing and investigating health practitioners to make sure they make the standards of good practice set for them by each of the national boards”<sup>1</sup> and “AHPRA does not make decisions about how to deal with notifications. These decisions are made by Boards [National].”** In 2011/12 there were 7594 notifications about health practitioners being managed by AHPRA.
6. In undertaking its functions the MBA advises, **“The Medical Board of Australia has delegated all powers necessary to deal with individual practitioner’s registration and notifications. References to “the Board” in this document mean “the delegated decision-maker”.**
7. AHPRA describes its relationship with Boards as “partnering with National Boards”, “support the National Boards”, and the Medical Board of Australia describes itself as “Working in partnership with AHPRA ...”. The ADF maintains that the reality is that AHPRA manages the National Boards on behalf of the Agency Management Committee, given that AHPRA manages the funds of the entire national registration process.
8. The point the Australian Doctors' Fund was trying to make at the Inquiry was that **under a single jurisdiction system, a constituent could make representation to their local member in the expectation that the complaint system was under the exclusive control of one parliament and a minister with direct authority over all agencies involved.** Clearly under the national scheme underpinned by the IGA, unless the states opt out of the IGA, the agencies managing complaints (AHPRA) and making decisions about complaints (MBA) are ultimately responsible to the Ministerial Council, not a single minister.
9. Queensland has now decided to bring their health complaints system back to within their state’s control (see more detailed explanation of the QLD issues below).
10. **The ADF is well aware that all parliamentarians and health ministers will always bring whatever pressure to bear they can to resolve constituent’s issues in relation to health complaints.** This

<sup>1</sup> Australian Health Practitioner Regulation Agency, Who does what, [www.ahpra.gov.au](http://www.ahpra.gov.au)

will include making representation to whatever agencies are involved and demanding answers and action. The point we are making is that these agencies in some states are now answerable to a Ministerial Council via a Board, not any single constituency. The difficulties and inefficiencies for constituents involved in this process have been outlined by Mr Richard Chesterman QC in his recent inquiry for the Queensland Parliament (see point 10-13 further in this report concerning the doctor who was wrongly labelled as having an issue).

#### Your request for further information

#### **Parliament's ability to disallow a regulation**

##### Response:

Disallowed regulations, Health Practitioner Regulation National Law (Victoria) Act 2009

#### **246 Parliamentary scrutiny of national regulations**

- (1) A regulation made under this Law may be disallowed in a participating jurisdiction by a House of the Parliament of that jurisdiction—
  - (a) in the same way that a regulation made under an Act of that jurisdiction may be disallowed; and
  - (b) as if the regulation had been tabled in the House on the first sitting day after the regulation was published by the Victorian Government Printer.
- (2) A regulation disallowed under subsection (1) does not cease to have effect in the participating jurisdiction, or any other participating jurisdiction, unless the regulation is disallowed in a majority of the participating jurisdictions.
- (3) If a regulation is disallowed in a majority of the participating jurisdictions, it ceases to have effect in all participating jurisdictions on the date of its disallowance in the last of the jurisdictions forming the majority.
- (4) In this section—

**regulation** includes a provision of a regulation.

#### Your request for further information

#### **The case raised by Mr O'Brien where the doctor was wrongly labelled as 'having an issue'.**

Response: I refer to the case of a QLD surgeon who does not wish to be named, but I am happy to supply his name and details to the Member for verification with the surgeon. The issue has arisen in QLD under the old system and the facts are as follows:

1. The surgeon applied in February 2013 to a QLD government agency to be a member of a tribunal from 1/7/2013 which required his medical expertise. (His application was to go before an assessment panel).
2. The agency advised the surgeon that AHPRA had informed the agency "of a matter it is investigating which relates to your registration as a medical practitioner".
3. The surgeon in question had no idea of any adverse matter or notification to AHPRA or anyone else and commenced an immediate investigation to clear his name so that he could be appointed to the tribunal (or not be excluded on the grounds of a false or wrongly classified notification to AHPRA)
4. The surgeon had great difficulty obtaining any information as to why a notification was made against him and was advised subsequently by the Director of Notifications for AHPRA that "privacy

- provisions detailed in Section 214-221 of the National Law prevented (name supplied) providing further details to you on this matter at the relevant time.”
5. The surgeon subsequently had found out that the notification was for another doctor of the same surname in respect to an obstetrics matter. The surgeon wrongly labelled has never practised obstetrics or treated the patient named in the notification.
  6. The evidence is clear that the notification made to AHPRA through the QLD Health Quality Complaints Commission was circulated to State government agencies prior to any verification of the accuracy of the complaint i.e. AHPRA had not sought to clarify the accuracy of the complaint it had received before allowing it to be circulated.
  7. On 1/3/2013, AHPRA wrote to the surgeon acknowledging the error and implicating the HQCC as the real culprit saying that it “would have no reason or authority to doubt the information provided by the HQCC” and chastising the surgeon for “the untoward tone of your emailed communication”.
  8. It took a substantial energetic effort on behalf of the surgeon and his staff to have this matter corrected. Had he not applied for a position with a QLD Government agency, it may have taken a much longer time to become aware that his reputation was wrongly under question.
  9. Under changes to the QLD legislation, the QLD Health Ombudsman will now be given the direct legislative authority to act for the complainant to achieve redress.
  10. There is no suggestion that any staff member in any agency is deliberately acting against natural justice. The statement we make is that additional steps in the process create more complexity and room for error and inefficiency. These statements have been absolutely substantiated by the recent report into inefficiencies in the health complaints process in QLD by Mr Richard Chesterman QC<sup>2</sup>, The report states, *“The cross jurisdictional referral and consultation obligations imposed respectively under the Health Practitioner (Professional Standards) Act 1999, Health Quality and Complaints Commission Act 2006 and the Health Practitioner Regulation National Law Act 2009, in relation to complaints/notifications, resulted in substantial delays and inconsistencies in the processing and outcomes of a significant number of files.”*
  11. In the same report Mr Chesterman draws attention to the fact that referrals from QLD Health Care Complaint Commission and other complaint agencies were not prioritised for processing, *“It is of concern to the panel that complaints/notifications received by AHPRA took little account, in terms of the application of the disciplinary process, of the source of the notification. The panel was concerned that notifications made by Queensland Health, private health care facilities and the Office of the State Coroner were treated in the same manner as notifications made by the public. The process did not provide the Board with the ability to expedite these notifications in a timely manner commensurate with the level of scrutiny and investigation that had been undertaken before the notification had been received by AHPRA.”*<sup>3</sup>
  12. Furthermore, Mr Chesterman categorically states, *“The panel was of the opinion that the current legislative requirement for two (2) separate and distinct entities to co-manage notifications through reciprocal referral and consultation processes is an unnecessary duplication of activities and resources and requires immediate consideration either to change the provisions of the legislation or consolidate the roles of the entities.”*<sup>4</sup>
  13. The ADF draws the Committee’s attention to the Memorandum of Understanding, Australian Health Practitioner Agency and Health Complaints Entities and the document “Schedule 2: Flow chart” which diagrams the flow of complaints as agreed across agencies with AHPRA.

### Your request for further information

### **The case of under reporting**

Response: The ADF draws the Committee’s attention to the following reference made by the QLD AMA on 19/6/2013 in its submission to the QLD Health Ombudsman’s Bill, *“AMA Queensland is deeply troubled by*

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<sup>2</sup> Final Report of the Chesterman Recommendation to Review Panel of 5/4/2013, p.xv

<sup>3</sup> Ibid, p.x

<sup>4</sup> Ibid, p.xxii

*the declining numbers of practitioners in Queensland seeking treatment from their peers since the introduction of the requirement for mandatory notification for health practitioners treating health practitioners. AMA Queensland is concerned that this regulatory regime “drives underground” health issues which could affect performance. This increases the chance that “near miss” events – which could present an opportunity for performance improvement or healthcare treatment will instead result in adverse patient outcomes.”*

Yours faithfully

A handwritten signature in black ink that reads "S Milgate". The signature is written in a cursive style with a large, looping initial 'S'.

Stephen Milgate  
Executive Director  
Australian Doctors' Fund