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SUBMISSION BY THE AUSTRALIAN SOCIETY OF ANAESTHETISTS TO THE COMMUNITY AFFAIRS COMMITTEE EXPOSURE DRAFT (BILL B) NATIONAL REGISTRATION AND ACCREDITATION SCHEME

Introduction

This subsequent Submission on the proposed National Registration and Accreditation Scheme is to be read in conjunction with the primary Submission made to the Senate Inquiry on the National Registration and Accreditation Scheme for Health Practitioners submitted on 29 April 2009 by the Australian Society of Anaesthetists (ASA) (copy attached).

Since the original submission, the ASA is pleased to observe modifications that have been made as a result of comments and responses to the initial consultation process. However the exposure draft of Bill B raises some new issues. This submission focuses on remaining concerns for patient safety, quality and professionalism.

Inconsistencies between the Object of the Law and its stated Objectives

There is an apparent contravention of the objects as stated in Part I, 4, (1), (a): "*to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered*".

These contraventions may arise through several clauses in Part I, viz:

4,(1), (e) to facilitate access to services provided by health practitioners in accordance with the public interest. And...

4,(1),(f) 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. And through the power of endorsement of the Ministerial Council:

13. Approval of areas of practice for purposes of endorsement

The Ministerial Council may, on the recommendation of a National Board, approve an area of practice in the health profession for which the Board is established as being an area of practice for which the registration of a health practitioner registered in the profession may be endorsed.

These clauses would permit the accreditation of practitioners on the basis of workforce provision through competencies rather than the longstanding accreditation processes based on quality and safety through an appropriately identified knowledge base. Accreditation standards driven by workforce pressures will lead to a reduction in quality through a competency-based framework rather than a profession underpinned by substantive training.

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Attachement 1

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Executive Summary

The Australian Society of Anaesthetists (ASA) wholeheartedly supports the concept of National Registration of medical practitioners to the extent that it would allow the easy transition of practice from State to State and hence enhance the provision of anaesthetic services to the community.

In the interests of the safety and healthcare of community members (our patients), the ASA is, however, opposed to the Inter-Governmental Agreement (IGA) that plans to deconstruct the current nationally based system of accreditation and training by removing the responsibility for registration, accreditation and training from the appropriate healthcare professions and placing it in the hands of Ministers and bureaucrats who may be driven by ideological or fiscal policy rather than what is actually in the best health interests of our patients.

The Government has provided no justification for proposing, or evidence to support, the introduction of completely new arrangements for the accreditation of medical education and training in Australia. In 2005 Professor Stephen Duckett, the architect of the Government's current proposals, published an article in the journal Australia & New Zealand Health Policy titled "*Interventions to facilitate health workforce restructure*". In it he uses unscientific phrases such as "*perceived shortages of most categories of health professionals*"; "*current assignment of health professions is perceived to be inefficient*"; and again, "*specialisation is now seen as possibly detracting from continuity of care and hence may have a deleterious impact on quality*".

Another major concern is the significant cost involved in the establishment and maintenance of the proposed system, which involves a whole new layer of bureaucracy. Reference is made in the Government's Consultation Papers that the cost will be met by registration fees charged to the users, namely, members of the professions and bodies seeking accreditation. It would appear that the existing State registration entities are not being abolished but rebadged or even further enhanced with new committees to represent the functions of the Federal bodies in each State jurisdiction. The question needs to be asked: "Who will be paying for all of this?"

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The ASA seeks leave to be represented before the Community Affairs Committee to elaborate on this Submission.

BACKGROUND

The Australian Society of Anaesthetists (ASA) was founded as a voluntary organization in 1934. It represents the fourth largest body of medical personnel in Australia. Its membership comprises more than 70% of specialist anaesthetists across the country with 84% of specialist anaesthetists in the most populous State, New South Wales, being members. Many General Practitioner anaesthetists are also members.

The ASA, whose main objective is "to advance the science and art of anaesthesia and related disciplines in Australia in order to achieve international best practice", has 35 committees dealing with a broad range of issues, including: continuing education of members; providing information to the community; special anaesthesia-related interest groups; overseas anaesthesia aid; publishing the internationally recognized Australian scientific journal "*Anaesthesia and Intensive Care*"; liaising with many organizations, including but not limited to: Government Departments such as Medicare Australia, the Department of Veterans' Affairs and the Australian Competition & Consumer Commission (ACCC); the Australian & New Zealand College of Anaesthetists (ANZCA) concerning education, workforce and anaesthesia incidents; the Australian Medical Association (AMA); and Private Health Insurers. Amongst other activities the ASA also provides a locum service and a Benevolent Fund for the benefit of members.

The ASA was instrumental in establishing the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1952 to provide formal training of anaesthetists in Australia. This Faculty became independent, as ANZCA, in 1992.

The ASA has been a leader in the field of medical critical event reporting and analysis. Active support has been provided to the Anaesthetic Incident Monitoring System (AIMS) and the Australian Patient Safety Foundation (APSF) in collating their databases on anaesthetic-related problems. This involvement has contributed enormously to overall patient safety in operating rooms.

OBJECTIVE

The objective of the ASA's Submission to the Senate's Community Affairs Committee is to identify the benefits as well as the significant weaknesses and risks to the quality and safety of health services in Australia proposed by the IGA's proposed concept for a National Registration and Accreditation Scheme (NRAS).

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Patient Safety

Despite the Government's statements in the Consultation Paper on Accreditation that "*the safety of the public is paramount*" and "*high quality health care must be protected and advanced*", there is the potential for the IGA to allow less qualified practitioners to provide healthcare services to the Australian people. It will allow healthcare professionals of one group to undertake tasks normally reserved for another group and for which they are less well qualified or inadequately trained to perform. This is known as "task substitution" and will greatly diminish the current, internationally recognized high standard of healthcare (surrounding anaesthesia in particular) in Australia.

Due to the long-standing commitment to training and accreditation activities by ANZCA, the commitment to and support of research and continuing professional development by the ASA and ANZCA, as well as advances in pharmacology and technology adopted by the members of the profession, mortality from anaesthesia in Australia has decreased significantly over the years (*vide infra - Table 1*). In 1986 a study by the National Health & Medical Research Council and involving the New South Wales Special Committee Investigating Deaths Under Anaesthesia showed that it was four times safer to be anaesthetized in Australia than in either the United States or the United Kingdom (refer to graph in Annex 1). With the notable figures in Table 1 and the fact that anaesthesia and sedation is administered by non-specialists in both the US and UK, there is no reason to believe that the comparison with other countries is any different these days to that shown in Annex 1. The Senate should not allow our standards of anaesthesia to be diminished by the proposed scheme, which, as stated above and *inter alia*, advocates "task substitution" or "cross-pollination" by lesser qualified personnel from other healthcare professions. Quality of care and patient safety can be expected to adversely impact upon and the lives of Australian patients put at risk under the guise of this proposed "National Registration and Accreditation" scheme (the NRA).

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TABLE 1

ANAESTHESIA MORTALITY IN AUSTRALIA

YEAR	COMBINED SURGICAL AND ANAESTHETIC CAUSES	SOLELY ATTRIBUTABLE TO ANAESTHESIA
1950	1 IN 1,000	
1960		1 IN 5,000
1970		1 IN 10,000
1990		1 IN 20,000
1996		1 IN 154,000
1999		1 IN 220,000
2002	1 IN 63,000	
2006	1 IN 80,000	

Sources:

1. *ANZCA compilation of figures from State-based "Deaths Under Anaesthesia Committees".*
2. *Gibbs: Safety of Anaesthesia in Australia - A Review of Anaesthesia-Related Mortality 2000-2002.*

Given that ASA members have to constantly deal with the potential for morbidity and mortality, due to

- the intrinsic/existing pathophysiology of patients
- the potential for reactions to drugs or procedures or
- difficulties with such mechanical processes as airway management and vascular access,

the ASA is most concerned that the arrangements mooted by the NRA proposals will result in under-trained and under-qualified personnel assuming some of the roles traditionally performed by medically trained specialist anaesthetists. Personal communication from Professor Ross Holland from the NSW Deaths Under Anaesthesia Committee show that, where errors of judgment are involved in anaesthesia, it may take only just one error for a patient to die, particularly with the older and sicker patients encountered these days with Australia's aging population. Critical decisions need to be made within seconds in times of

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anaesthetic emergencies. The luxury of time for lengthy consideration of a problem does not exist.

To avoid disastrous consequences, only highly trained personnel should be authorized to administer anaesthesia. Unfortunately, as stated earlier, the proposed scheme includes plans for the accreditation of under-qualified personnel to undertake tasks for which they will not have been adequately trained.

To become a specialist anaesthetist involves a total of 13 or 14 (depending on which university one attends) years of medical training – 5 or 6 years of undergraduate medical studies at university, 3 years hospital-based training in a variety of medical disciplines and then 5 years directed, dedicated and supervised training as a Registrar in anaesthesia. Two major examinations conducted by ANZCA must be passed before the completion of the latter 5 years in order to become a specialist. This dedicated training period has, over the last 50 years, increased from 2 to the current 5 years due to the expanding requirements and demands for knowledge and safe practice. Again according to Professor Ross Holland from the NSW Deaths Under Anaesthesia Committee, "education and training play the major part" in the reduction of perioperative mortality.

It is important to understand that it is not just some technical skill that is required to keep patients safe and alive but it is also the ability of highly trained anaesthetists to serve as "perioperative physicians", assessing and caring for patients' medical conditions before and after surgical procedures, that contributes to the survival of patients undergoing anaesthesia and surgery.

REGISTRATION

The ASA believes that "national registration" as a separate defined entity, allowing "portability" of registration, is a desirable objective allowing the medical profession to be able to supply services in many places not currently readily accessible. This would enhance the provision of services to the general community of Australia. The current standards for registration of medical practitioners in each Australian State are equivalent and, upon the provision of the appropriate supporting data of qualifications, it is currently possible to become registered to practise in more than one State. It would be a simple matter to obtain a system of national recognition and registration without the addition of a large bureaucracy and significant expense that the IGA will bring to the Australian populace in general and the profession in particular. A simple coalescence of State-based databases would achieve this easily, quickly and relatively cheaply.

Costs

The IGA establishes the Ministerial Council of all Health Ministers, an Advisory Council, a National Agency with an Agency Management Committee, and, lastly, ten National Boards for each of the healthcare professions involved. As well as these new and expensive bodies,

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each jurisdiction (State) will have representative committees under the National Agency – presumably these will be the current State Registration Boards. The cost of this new but duplicated bureaucracy will be an enormous drain on the public purse as well as on the different health professions in the form of registration fees. The costs to the professions will, of course, have to be passed on to patients.

Workforce

The proposed scheme claims that it will result in an increase in workforce responsiveness, flexibility and sustainability. However it would seem that the real thrust of the IGA is to obtain "task substitution" whereby Ministers and bureaucrats can control (through policy directives/approvals to Boards) the registration of personnel with any level of qualification (including those with insufficient training and qualifications) in order to "enhance" workforce distribution. The ability of "cross-pollination" of registrants from one Board being licensed to perform tasks usually performed by those of another Board is already evidence of the Government's intentions in this regard. The introduction of nurse practitioners with prescribing powers is an existing example of what we consider to be a dangerous activity promoted by the IGA. The introduction of same is/would be at the expense of traditionally high quality care and result in putting patients' lives and well-being at risk.

It should also be noted that, when the Government raises the introduction of "nurse anaesthetists", it is ignoring the huge existing shortage of nurses across Australia. The current lack of nurses is making it extremely difficult to staff hospitals. This will become almost impossible should nursing roles be expanded outside their usual ambit.

Areas of Need

The discussion on task substitution leads into consideration of the legislation involving Area of Need (AON) whereby each Board would be capable of registering under-qualified personnel to provide services in certain geographical areas designated as AON by the Health Minister. AON is a problem recognized by the ASA. It can be solved, however, by the offering of appropriate incentives to properly qualified personnel. This type of solution is already exemplified in rural areas by the provision of locum anaesthetic services that cover weekends in several country hospitals. The fact that the Ministerial Council will also be able to issue "guidance" to the medical board on the criteria for specialist registration in AON is also of great concern and has significant implications for standards of healthcare and public safety.

Generic Terminology

The ASA is also concerned that the Government is introducing the generic term "health practitioner" that will cover all registrants of all ten Boards. Proposal 8.1.1 in the Consultation Paper on Registration allows all healthcare workers to call themselves "doctor". This will lead to confusion, (probably intentional on the part of the Government), amongst

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patients. Workers will not be able to use the specialist titles of "specialist anaesthetist", "surgeon", "paediatrician" or "obstetrician" etc. but the public will be misled on many occasions and matters of quality of care and patient safety will arise.

ACCREDITATION

In its Consultation Paper on Accreditation, the Government states in Clause 1.6 (b) that "*It is proposed that the provisions for accreditation functions: ensure that the process of assessment of courses and qualifications is undertaken independently from government, health professional educators and the profession.*" This statement is contradicted by the fact that the National Board's accreditation policies and processes have to be approved by the Ministerial Council and by Clause 1.34 of the same document, which states "*...the Ministerial Council...will assign accreditation functions to existing accreditation bodies, with the requirement that within the first 12 months of the new scheme, they meet standards and criteria set by the national agency for the establishment, governance and operation of external accreditation bodies, which will include: (a) Processes for assessing individual qualifications and courses of training that are rigorous, open, transparent and fair,* ***consistent with government policy****, and include adequate arrangements for review of accreditation decisions.*"

Australia's current nationally based system with its independence of accreditation of medical training through the Australian Medical Council (AMC) is in keeping with the international agreement made by the World Medical Association in Geneva in 2005, and re-affirmed in Seoul in 2008. The AMC, an independent body set up by the Government in 1984, is charged with:

- Accreditation of medical education;
- Assessment of overseas trained doctors;
- Uniformity of registration policies; and from 2000
- Accreditation of specialist training; and
- Advice on recognition of new specialities.

Specialist Training

The ASA is most concerned that there is no provision for the continued existence or participation of the learned Colleges. ANZCA provides all training and examinations for doctors who wish to become specialist anaesthetists. It also provides Continuing Professional Development (CPD) programs for practising anaesthetists. These are functions that can only be performed by qualified clinicians who are *au fait* with the science and the requirements of both the profession and the patients. To have any of these roles taken over by bureaucrats would be counter-intuitive, counter-productive and, in all likelihood, would result in a

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significant lowering of standards of delivery of anaesthesia care – in short a disaster! To allow any alteration to this mechanism would be doing a grave disservice to the population of Australia.

Recognition as a specialist anaesthetist (or any medical specialist category for that matter) should not be left up to bureaucratic or Ministerial directions for National Boards to provide endorsements. Recognition should only be provided by certification from a medical College – ANZCA in the case of anaesthetists.

The ASA believes that, for the appropriate accreditation of courses and personnel in the specialty of anaesthesia, the current totally independent mechanism is the best option and the safest one for the maintenance of the highest standards of anaesthesia and ultimately the protection of members of the public. The ASA believes, in order to fulfil the aims of Clause 1.6 (a) of the Consultation Paper, namely, "*It is proposed that the provisions for accreditation functions: provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered and that practitioners have the skills and competencies to meet the health needs of the Australian community*", that the only appropriate training that will lead to the present high standard of anaesthetic outcomes is that which is currently accredited by the AMC and operated (or recognized in the case of Overseas Trained Doctors) and certified by ANZCA. To accredit anyone else or any lesser course would inflict a greater anaesthetic risk on the public.

The proposed scheme does not guarantee the existence or utilization of these essential and independent bodies (the AMC and ANZCA) after the first three years.

Although the Consultation Paper states that "*the Ministerial Council has no role in the accreditation of specific courses or individuals and can only approve standards when recommended by the relevant national board*", the Ministerial Council is charged, in Clause 3.2 (a), with the task of "setting the policy direction". This, coupled with the ability of individual national boards to organize approval of any of their own registrants to undertake "task substitution" activities, without any reference to any of the other national boards (e.g. introducing much lesser trained nurse anaesthetists), will allow for Government interference in the healthcare of the populace. This would be in direct conflict with the "Declaration of Seoul" made by the World Medical Association in 2008 (vide Annex 2).

Again, the Government contradicts itself in Clause 3.10 of the Accreditation Consultation Paper when the following statement, providing for Government control, states: "*The accreditation standards framework developed by the agency following consultation with the boards will set down requirements for the accreditation process which will ensure that good regulatory practice is followed* ***and Ministerial directions are met****.*" and is followed by an attempt at justification by quoting from the World Health Organization/World Federation of Medical Education *Guidelines for Accreditation of Basic Medical Education* (2005) stating

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that: "*The accreditation system must operate within a legal framework.....The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment* ***from government****, the medical schools and the profession.*" Here, the Paper (i.e. the Government) is at odds with itself in an attempt to confuse the professions.

The ASA expresses its overwhelming concern regarding the intent of the Government in reference to contradictions detailed above. The expertise developed by the AMC over the last 25 years, as well as its high national and international standing should mean that its future, beyond an initial 3 years, is assured.

International Experience

Following the aforementioned World Health Organisation/World Federation for Medical Education *Guidelines for Accreditation of Basic Medical Education* (Geneva/Copenhagen 2005) agreement, the ability of the Government to interfere in the training, registration and accreditation of medical personnel, as proposed under the NRA, will severely limit the ability of overseas students and graduates to obtain recognition for time spent gaining experience in Australia. Conversely, Australian graduates may not have their training recognized overseas. It would be to the severe detriment of both the Australian medical profession and population at large if the current international exchange of experience was thwarted by the proposed loss of independent training, registration and accreditation.

COMPLAINTS and DISCIPLINE

The plans for a national complaints body and system will be a backward step. The ASA believes that the present system of State-based complaints and disciplinary tribunals should be preserved. It means that healthcare workers in all sectors are dealt with at a local level with reference to local conditions and State laws. While each State has developed its own mechanisms for dealing with these difficult situations, the current New South Wales model, which is consistent with international best practice, stands out as possessing the best model nationally. Not only does it provide for full investigation and legal process but it also has an excellent program for rehabilitation of impaired healthcare workers meaning that many of these are not lost permanently to the healthcare system. A nationally consistent system could be achieved through the harmonisation of State legislation rather than deconstructing an effective and tested model in favour of an untried and potentially cumbersome new system.

CONCLUSION

The "National Registration and Accreditation" scheme is much more than the name would suggest. If the scheme is introduced as mooted, it will be a very costly overlay and will create risks for the health and well-being of the public. There will be the ability for the healthcare system to be manipulated directly for political purposes at the expense of the welfare of community members. Clinical independence may be corrupted to the detriment of the

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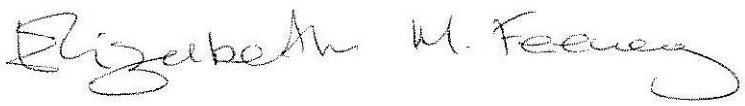
populace. Standards of treatment will fall because of task substitution and, therefore, morbidity and mortality from surgical/anaesthetic procedures, indeed any medical care, will inevitably rise. People may well be misled by the use of the generic term "healthcare professional" or the (mis-)use of the title "doctor", available to a significantly widened and non-descript group of healthcare workers, some categories of whom may yet not exist in Australia!

RECOMMENDATIONS

The ASA respectfully requests the Members of the Australian Senate to seriously include the following recommendations in their deliberations on the Government's "National Registration and Accreditation" proposal:

1. Provide national registration for all the healthcare professions by a simple coalescence of State-based databases;
2. Maintain the present national system of training and accreditation, preserving the time-tested expertise developed by and through the learned medical colleges;
3. Prevent political and bureaucratic interference in training, registration and accreditation, preserving the decades of experience vested in the independent Australian Medical Council;
4. Retain the present system of State-based disciplinary bodies for handling complaints;
5. Avoid the costs of establishing a whole new layer of unnecessary bureaucracy; and
6. Take heed of the exceptionally low mortality statistics of Australian specialist anaesthetists and avoid the introduction of under-trained and under-qualified task-substitutes.



Dr Elizabeth Feeney
PRESIDENT
28 April 2009

Annexes:

1. International comparisons - Death rate from Anaesthetic mishaps (per 10,000 operations) – 1986.

2. Declaration of Seoul on professional autonomy and clinical independence.

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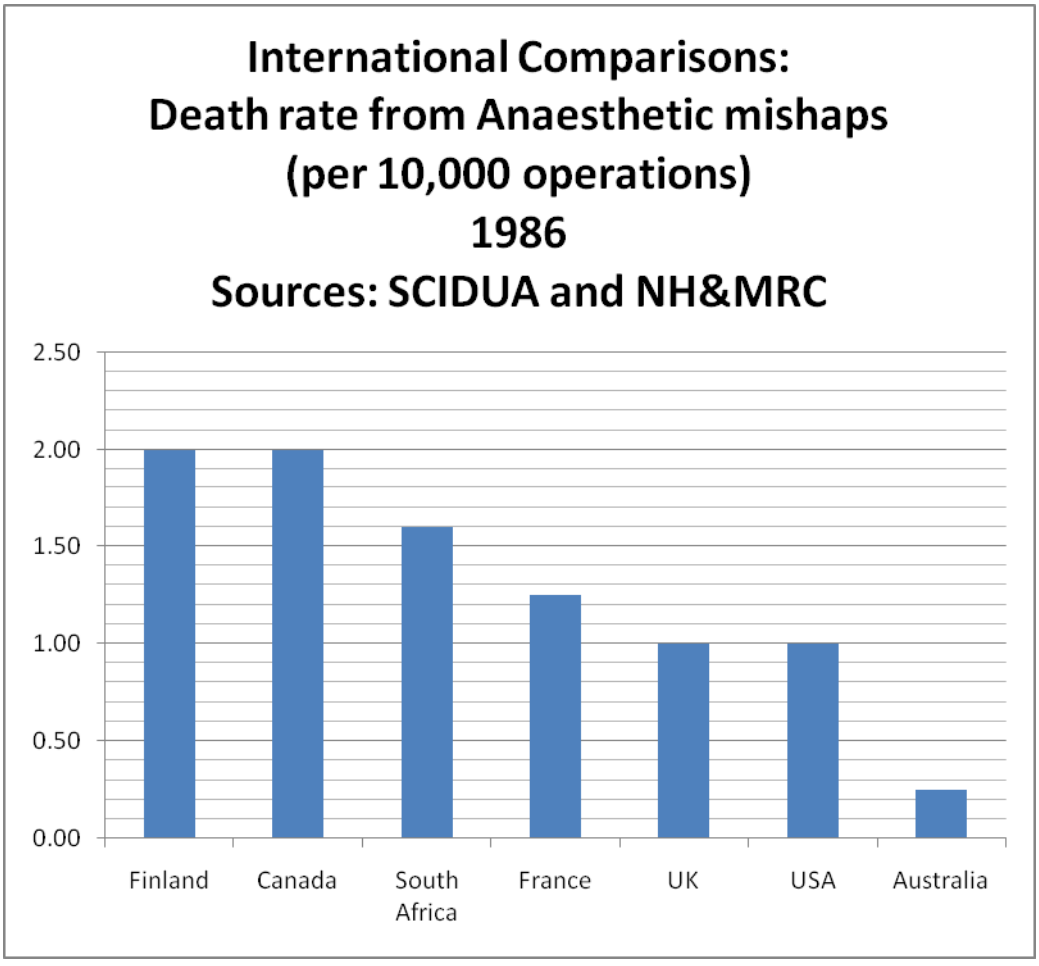
ANNEX 1

International comparisons - Death rate from Anaesthetic mishaps (per 10,000 operations) - 1986



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ANNEX 2

DECLARATION OF SEOUL

on

PROFESSIONAL AUTONOMY and CLINICAL INDEPENDENCE

The World Medical Association, having explored the importance of professional autonomy and physician clinical independence, hereby adopts the following principles:

1. The central element of professional autonomy and clinical independence is the assurance that the individual physicians have the freedom to exercise their professional judgement in the care and treatment of their patients without undue influence by outside parties or individuals.

2. Medicine is a highly complex art and science. Through lengthy training and experience, physicians become medical experts and healers. Whereas patients have the right to decide to a large extent which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.

3. Although physicians recognise that they must take into account the structure of the health system and available resources, unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients, not least because they can damage the trust which is an essential component of the patient-physician relationship.

4. Hospital administrators and third-party payers may consider physician professional autonomy to be incompatible with prudent management of health care costs. However, the restraints that administrator and third-party payers attempt to place on clinical independence may not be in the best interests of patients. Furthermore, restraints on the ability of physicians to refuse demands by patients or their families for inappropriate medical services are not in the best interests of either patients or society.

5. The World Medical Association reaffirms the importance of professional autonomy and clinical independence not only as an essential component of high quality medical care and therefore a benefit to the patient that must be preserved, but also an essential principle of medical professionalism. The World Medical Association therefore re-dedicates itself to maintaining and assuring the continuation of professional autonomy and clinical independence in the care of patients

Adopted by World Medical Association General Assembly, Seoul, Korea, October 2008

Adopted by Australian Medical Association, March 2009

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This is stated elsewhere in the Bill, allowing practitioners to be registered for a "corresponding purpose" that endorses practitioners to function in a role that they are not primarily registered for and are not trained to the same level of competence as would normally be the case with an appropriately registered practitioner.

This ability to "task substitute" by lesser trained and lesser qualified practitioners is not in the public interest. It can only put the general public at risk and should not be allowed.

The new draft Bill does make a small concession on this problem with Part 5, 51, whereby other Boards now have to refer to respective Boards if making recommendations to the Ministerial Council on matters related to the other Board. This unfortunately does not oblige the first Board to follow the advice from the second Board whose area of expertise is being encroached upon. Nor does it prevent political expediency by the Ministerial Council.

The problem is again seen in Part 7, 77, where a National Board can make an ordinary practitioner a "specialist" without examination or proper assessment. Surely, this enables scope for future problems.

The purpose of not providing for the protection or reservation of certain titles for doctors is questioned. While reserving "medical practitioner" and "medical specialist", none of the following are protected titles: doctor, anaesthetist, surgeon, obstetrician, paediatrician gastroenterologist, ophthalmologist, radiologist, psychiatrist, etc. Part 7, 131-133 affords some restriction on the use of titles. It would seem that any health practitioner could possibly make use of one or more of these unprotected titles. An unsuspecting public could easily be misled in the level of treatment they could expect to receive. Protection and appropriate restriction in the use of these well-known and recognizable titles must be introduced into any new legislation.

Independence from Government

This is another feature of this legislation that has not been addressed in the draft Bill. The Ministerial Council (Government) remains able to issue policy directions (refer Part 2, 10). It can also dictate accreditation standards, making them higher or even lower according to political exigencies or workforce numbers etc. (refer Part 2, 10, 3, d and Part 2, 11). The Council is also still reserving the right to approve registration standards (refer Part 5, Div 2, 49, (a), (ii)).

Hence the projected difficulties continue with the recognition of training for overseas students coming to Australia and overseas recognition for Australian graduates because of the possibility of interference by Government to affect policy initiatives. As pointed out in our previous submission, this contravenes guidelines and resolutions from the World Health Organization, and undermines the Australian medical system's current high standing in the international arena.

Accreditation

The Bill continues to give no guarantee that the present, independent accrediting body, the Australian Medical Council, will survive beyond the first three years (refer Part 12, 290, (6)). Even more concerning is the fact that the Ministerial Council can appoint any other body it

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chooses as an accrediting body despite any recommendations from the relevant Board (refer Part 6, Div 2, 60).

The ASA again strongly recommends that the Australian Medical Council be retained permanently to act independently, as it does now, in its accreditation functions for the medical profession.

Indemnity

Part 7, 73 of the draft Bill requires indemnity to not expire before registration does. Currently, registration is granted only after proof of indemnity has been supplied. Each of these entities is renewed annually, currently these 'years' do not correspond. Compliance with this new requirement will be onerous for indemnifiers, the Board and registrants unless a common date for renewal is legislated for.

In Part 7, 101 having indemnity insurance has been set as a condition of practice rather than a requirement of practice. Conditions of practice are restraints that have been placed on practice by tribunals and have generally reflected limitations due to deficiencies. If Part 7, 101 is maintained then all registrants will have to state that they have conditional registration. This will cause great confusion not only for those verifying registration but also for the public at large. This is surely unintended under this legislation and should be amended to reflect the current 'requirement' that exists in some jurisdictions.

Continuing Professional Development

At 125(3), it is noted that there is a reference to continuing professional development as a 'condition' of practice. As stated above, this is unnecessary and will cause considerable confusion to the public. These obligations should again be stimulated as a requirement for registration and not as a condition of practice.

Billing Privileges

Part 7, 124(d) states the requirement for the registrant to disclose the withdrawal or restriction of billing privileges by Medicare Australia or a private insurer. It is acknowledged that inappropriate billing practices can, in some circumstances, be an indicator of inappropriate practice however this clause appears very broad and should be amended to the disclosure of decisions by the Professional Services Review Committee or by similarly constituted review bodies rather than by private insurers who are not operating at arms length with practitioners.

A similar amendment should apply to Part 7, 142(3)(c) in relation to the obligation of the practitioner to provide information to the Board relating to withdrawal of billing privileges. Private health insurers are not the appropriate bodies to be making decisions in relation to practitioner's conduct, performance or health. The wording of this clause is surely erroneous.

Complaints Handling

Part 8 Div 2, 153 allows for a complainant to make a complaint over the telephone. As such a mechanism of complaint is obviously open to the possibility of mischievousness. Any complaints should be required to be formalised in writing and signed off by the complainant. The National Agency must establish the true identity and *bona fides* of someone making a complaint by this means before acting upon such complaint. Despite a fine of $5,000.00 listed in Part 8 Subdiv 5, 239 for impersonation of an official complaints investigator, Part 8 Subdiv 2, 216,(2) allows the possibility of anyone doing at least preliminary investigations in an

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establishment without producing an ID card. This section of the Bill should be made absolutely watertight to prevent any impersonation at all.

Owners & Operators of Health Establishments

Part 7 Subdiv 6, 148 (2) provides scope for the owners or operators of health establishments to entice a health professional to engage in unprofessional conduct or professional misconduct, without obvious penalty. As either employers of health practitioners or people able to grant or deny access to work environments to health professionals, owners or operators of health establishments may have a significant influence on staff. As such, there may well be occasions where they could be responsible for influencing a health professional's actions. In such cases said owners or operators should be accountable.

Information in Register

In the case of conditional registration due to impairment, Part 10 Division 3, 272, makes an exception for the impairment not to be disclosed. Whilst it is acknowledged that it is in the public interest for conditional registration to be recorded, under no circumstances should the nature of a practitioner's impairment ever be disclosed or published.

Conclusion

The ASA acknowledges significant improvements have been made in the draft Bill. There are still further patient safety, quality and professional issues that are inadequately addressed. Without modification, the ASA is concerned that the flawed legislation will disadvantage Australia's health services and therefore the health of Australians.

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