# ADF Submission
# on the exposure draft of the
# Health Practitioner Regulation National Law 2009

## 12 July 2009

*There is a better way*

**Recommendations**

1. That the Australian medical profession be removed as one of the groups listed in Bill B of the Health Practitioner Regulation National Law 2009.

2. That parliamentarians urgently call for an independent cost-benefit analysis and patient and public safety impact statement into the changes outlined in the national registration and accreditation scheme as detailed in Bill B.

3. That administrative reform for the Australian medical profession be achieved through the existing framework.

    a. By upgrading the computer database known as the National Compendium of Medical Registers to accommodate stream-lined registration procedures.
    b. By providing greater support to the established Joint Medical Boards Advisory Committee (JMBAC) which consists of the Presidents of Medical Boards of each state. JMBAC has been established for 20 years.

## Conflicting Objects and Objectives

The objects and objectives of Bill B are conflicting.

We are told that, ***"the object of this law is to protect the public"*** and listed in the objectives is an objective concerning ***"innovation in the education of, and the service delivery by health practitioners"***.

The later is code for workforce experimentation on the public. i.e. delegate a range of complex medical procedures to the lowest cost worker.

The idea of deregulating scopes of practice is the brainchild of Professor Stephen Duckett, the lead author of the national registration scheme and the objects outlined in Bill B. Professor Duckett's theories are outlined in his paper entitled, "Interventions to facilitate health workforce restructure".[1]

Professor Duckett's recommendations include deregulating anaesthesia, wound closure, foot surgery, endoscopy, maternity care, and x-ray.[2]

Under the object of protecting the public in Bill B, the titles of 'doctor' and 'surgeon' can be widely used by any person involved in health care. As such substantial advertising and counter-advertising over the meaning of titles and qualifications can be expected.

According to Ms Turnbull, legal adviser to Avant, Australia's largest medical indemnity insurer, "There was significant potential for the public to be misled." It appears the title 'specialist' will also be widely available without sanction'.[3]

Under the object of protecting the public, Bill B proposes to punish any person who directs or incites a registered health practitioner *"to do anything in the course of the practitioners practice of the health profession, that amounts to unprofessional conduct or professional misconduct"*, but excludes the owner or operator of a public health facility, or a licensed health facility under a law of the Commonwealth or participating jurisdiction.

## Problematic and Complex

Bill B magnifies complexities and inconsistencies that come from attempting to regimen a diverse group of medical and health professions and occupations, and as such opens a Pandora's Box of potential future problems, which is why NSW Health Minister John De La Bosca described it as, "problematic".[4]

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[1] SJ Duckett, *Interventions to facilitate health workforce restructure*, Australia and New Zealand Health Policy, 2005

[2] Ibid. table 1, page 2.

[3] Sarah Colyer, *Anyone can be a 'doctor'*, Australian Doctor, 10 July 2009.

[4] John De La Bosca, Speech to attendees at a forum into Bill B, Wednesday, 24 June 2009, Parliament House Theatrette, Macquarie Street Sydney.

This view was also shared by Dr Louise Morauta, Project Director, National Registration and Accreditation Implementation Project, who told the Senate Standing Committee on Community Affairs on 7 May 2009, *"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. We have a few things a bit like that around where there is an IGA, which is the mechanism by which ministers reach agreement before laws go through the system."* [5]

The Australian Medical Council has also noted, *"Given that in the order of 400 000 health professionals may eventually need to be accommodated, involving some nine professions and potentially 90 registration bodies, the scale of this task is substantial."* [6]

Furthermore, on 12 June 2009 the National Health Workforce Taskforce (NHWT), operating out of the Department of Health in Victoria put out a document entitled "Frequently Asked Questions" (referring to Bill B). There are 79 frequently asked questions listed. It would appear there is already substantial confusion, even among experienced policy makers and health administrators over the application of Bill B and related changes.

**Jurisdictionally Flawed**

Bill B introduces the concept of the unaccountable governance of an unelected COAG. **It means that one of the most complex and problematic pieces of health policy ever devised in the history of Australia will have no controlling jurisdiction**. It is an orphan with 9 mothers, none of whom can claim any legal responsibility for their child.

According to its nominal mother, Dr Louise Morauta, ***"The Boards are accountable to ministers; it's just that they are accountable to multiple ministers."***[7]

The Bill also creates confusion and contradiction between state jurisdictions by stating that a disallowed regulation in a state parliament *"does not cease to have affect in the participating jurisdiction………… unless the regulation is disallowed by a house of parliaments of a majority of the participating jurisdictions."(286.2)* This effectively means **that a State Parliament having rejected a regulation has no jurisdiction or mandate in its own state** and its constituents are to be governed by other state parliaments. This is most bizarre to say the least.

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[5] Dr Louise Morauta, Project Director, National Registration and Accreditation Implementation Project, Senate Hansard, Senate Standing Committee on Community Affairs Inquiry into National Registration & Accreditation Scheme for Doctors & other healthcare workers, 7 May 2009

[6] Response to the Second COAG Consultation paper on a National Health Professions Registration and Accreditation Scheme, Australian Medical Council, (undated).

[7] Dr Louise Morauta, Project Director, National Registration and Accreditation Implementation Project, Senate Hansard, Senate Standing Committee on Community Affairs Inquiry into National Registration & Accreditation Scheme for Doctors & other healthcare workers, 7 May 2009

**Other Ongoing Hazards**

There are a host of due process problems that would occur if Bill B were implemented including the definition of unprofessional conduct, and what constitutes the definition of *"influencing or attempting to influence the conduct of another registered practitioner in a way that may compromise patient care."* Events under this definition could include legitimate industrial and professional representation of medical practitioners. Other areas of concern include mandatory reporting, the role of the independent assessor, the role of 'the agency', and the role of the public interest assessor, (a late unannounced addition).

Nor has the issue of independent accreditation been resolved with any certainty and given Professor Duckett's recommendations for "work-based programs to address skills gaps"[8] there is every likelihood that future accreditation agencies will be bypassed in favour of short course certificates of competency which has lowered the standard of surgical care in the UK.

Professors Komesaroff and Kerridge have detailed the flaws in a proposed national code of professional conduct.[9] This allied document will become in all possibility an instrument of what Professors Komesaroff describes as "creeping authoritarianism".

Given the magnitude of issues raised by other recognised medical groups, this submission has restrained itself; suffice to say that our analysis yielded 45 major areas of concern with the legislation.

**Conclusion**

Bill B is part of a solution searching for a problem. Those who advocate significant change have a duty to put forward a compelling case for overturning a model that has delivered the second highest life expectancy in the world. Problems have occurred when the system of quality filters and professional requirements have been bypassed by decision makers who chose to ignore or were unaware of the consequences. Bill B offers no reassurance that highly publicised problems will not reoccur. We maintain Bill B will provide more scope for the lowering of accepted medical treatment standards in response to external agendas.

"Australia's health system has many strengths. Overall the health outcomes compare quite favourably with those in other developed countries. For example, Australians have among the highest life expectancies in the world - including when 'disability adjusted' for years of 'good health'. Yet total spending on health care as a percentage of GDP and per capita is not overly high by advanced OECD country standards (AIHW 2004a)."[10]

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[8] SJ Duckett, *Interventions to facilitate health workforce restructure*, Australia and New Zealand Health Policy, 2005, page 3.

[9] Paul A Komesaroff and Ian Kerridge, *The AMC Draft Code of Professional Conduct. Good practice or creeping authoritarianism?* 18 April 2009

[10] Australia's Health Workforce, *Productivity Commission Research Report*, 22 Dec 2005

There is no compelling case or public demand for changing the way doctors have traditionally been educated, trained and recognised. The national interest requires public confidence in the medical profession. **Any attempt to de-medicalise the Australian medical workforce will generate public anxiety and uncertainty at a time when Australians want security and predictability**. The medical profession should be removed from Bill B, and the recommendations outlined in this submission be implemented in the interest of patient care and public safety.

Parliamentarians will be interested in the views of Dr John Black, President of the Royal College of Surgeons, England, who has experienced many of the proposals outlined in Bill B. He wrote on 31 March 2009, *"One frustration of the present fiasco is that although we all know that training has been compromised, with frighteningly thin logbooks due to surgeons in training not getting to theatre and outpatient clinics, trainees are being signed off as having achieved their competencies and allowed to proceed. … **'If it ain't broke, don't fix it'** is a sensible way to conduct business, forgotten in the modernisation mania of the last decade, where everything had to be changed on principle. We now realise that a lot of babies were thrown out with the bathwater."*[11]

Stephen Milgate
Executive Director
Australian Doctors' Fund

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[11] President's Newsletter, The Royal College of Surgeons, England, Bulletin, March 2009, 91:154-155